A YEAR WITH OSLER

1896—1897

PHOTOGRAPH OF DR. OSLER TAKEN ABOUT THE TIME HE GAVE THESE CLINICS.

A YEAR WITH OSLER
1896—1897

Notes taken at his Clinics
in
The Johns Hopkins Hospital

By
JOSEPH H. PRATT
A MEMBER OF THE CLASS OF 1898

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INTRODUCTION

IT HAS BEEN SAID that the mark which always distinguishes the truly great man is that his greatness is more and more appreciated as we move farther away. Measured by this test, Sir William Osler is truly great. Although he left this country for England over forty years ago, and has now been dead for twenty-nine years, the passage of time has only served to increase the eminence of his position as a man and a physician.

No medical man ever received more tributes of affection from his professional brethren than did Dr. Osler and possibly the death of no physician was ever mourned by a greater host of friends. He was a many-sided man with many ties and affiliations. In him the medical profession in Canada, in the United States, and in Great Britain had a commond bond. When he went from Baltimore to England to become Regius Professor of Medicine at Oxford, Osler left behind him a " continent of friends." Five hundred medical men from all parts of the country gathered in New York at the Waldorf-Astoria to sit with him at a farewell dinner.

Sir William Osler was of medium size, well built, and graceful in his movements. His complexion was sallow, almost olive hued, possibly an inheritance from Celtic ancestors in Cornwall, the birthplace of his parents. I have heard his friend, Dr. George A. Gibson of Edinburgh, assert that no Anglo-Saxon could have his gayety of spirits. His eyes were luminous and searching, but often twinkled merrily. He wore a rather heavy, drooping mustache which partly concealed a strong mouth. A study of his photographs shows that his expression in repose became more genial as he grew older. In his earlier pictures his face is rather stern. He himself said that sobriety was reflected in his facies. His hands and wrists were unusually well formed and how effective and characteristic were the gestures he made with them.

The influence of Osler was exerted in many ways on the practice of medicine but even more by his character and life

than by his teaching or writing. When a young man, he chose "a path to a clear purposed goal." He had studied a year in preparation for the Church when he heeded the inner call to become a physician instead of a priest. This shift in plans meant with him no lowering of ideals, no change in the fixed purpose of his life. Osler doubtless thought—and rightly so—that he could be of as much service to humanity or more in the profession he finally chose. He always obeyed the commandment of Christ: "Thou shalt love thy neighbor as thyself." He acted on his belief, "that we are here not to get all we can out of life for ourselves, but to try to make the lives of others happier." In the loving kindness that shone forth in innumerable acts, there was seen humanity at its best, the divine spirit dwelling in the heart of man. Where Osler lived, there Unity, Peace and Concord also dwelt. They followed him from Montreal to Philadelphia, to Baltimore, and then to Oxford. In the long period at Johns Hopkins, the influence he exerted extended throughout the profession of the State of Maryland, as well as the City of Baltimore, and harmony reigned. He would not listen to gossip nor was he known to speak ill of anyone. There were, of course, men whom he did not like, but he did not talk about them and probably did not waste time thinking of their shortcomings.

He could, however, speak out boldly in public gatherings when he thought it his duty to do so. This is shown by the following incident that occurred at a meeting of the Association of American Physicians. This organization is composed of leading specialists in internal medicine and its membership was limited in Osler's day to less than two hundred. The council nominates new members at the annual meeting and has their names printed on slips of paper which are distributed to the members present when the election is held. This is largely a matter of form. The nominations of the council are accepted and the ballots are simply collected. Only on one occasion do I know of the rejection of anyone whose name appeared on the printed slip. This was when Dr. Osler arose in the audience to oppose the election of one of the nominees, who, he

stated, was only "a second-class general practitioner." The man was not worthy of membership but would have been elected if Dr. Osler had not spoken.

When testifying before a Congressional Committee in Washington on proposed antivivisection legislation, Dr. Osler in referring to different ranks of society used the expression "from politicians up."

He did not feel the pinpricks. Little things are only great to little men. I have seen him subjected to annoyances on several occasions that seemed to me very irritating, but there was no loss of his geniality and imperturbability. As Cushing truly says, "He would not have recognized jealousy had he met her, green eyes and all." In this ability to remain serene amidst the trials of life, and to banish disagreeable thoughts from his mind, he was following his philosophy of life, which he summed up in the watch-word, equanimity.

His generosity knew no limit. He gave away money and books, and even his own unpublished work, as the following incident shows: One of his favorite diseases was purpura. After asking me to write the section on this subject for his system of medicine, he turned over to me a large fasciculus filled with detailed notes of cases that he had seen, an unpublished lecture, and many abstracts and journal clippings. This material had been carefully gathered with the evident purpose of writing a monograph on purpura. Probably my full utilization of this material explains why his intent was never carried out.

Thoughts of distant friends were always coming to his mind. One day in Vienna, three years after he had left America, we were strolling along the street, and, passing by chance a bookstall, he stopped and said: "I will pick up something here to send Jacobi." He selected a small pamphlet and mailed it at once. The cost was so small—a mark or two—that anyone could have afforded it. He was often doing little acts of kindness like this, and always thinking of old friends. He recognized that the medical men in general practice form the bulwark of the medical profession, and he gave them every encourage-

ment within his power when they published anything in the way of clinical investigation that seemed valuable to him. So that many a lone worker, far removed from medical centers, has been encouraged and stimulated by receiving a few lines of approval from this leader of our profession. Soon after he had settled in England, he journeyed to Burnley to see that greatest of general practitioners of our generation, Dr. James Mackenzie, and to learn of his work at first hand. Dr. Mackenzie told me that Osler was the first and only English physician of note to visit him there.

It was regarded both a privilege and a duty by Osler to support the medical societies, with which he was connected, by regular attendance at their meetings. Long trips for this purpose were often made. These were apparently no hardship, so keenly interested was he in his medical brethren everywhere. He never lost his early attachment to pathology and in the spring of 1904, when pressure of work must have been heavy, he took the time to go to New York and spend an hour or two with the pathologists at their annual meeting. He rarely attempted to hear all of the papers or to attend every session. It was his custom to give a luncheon at the meetings to a few friends and to include one or more of the younger men. At the Vienna Congress of Internal Medicine in 1908, which I attended in his company, his guests invited to a luncheon were all younger clinicians and each of a different nationality—German, Dutch, Austrian and American.

Provincialism and chauvinism he regarded as the demons of ignorance. He urged a quinquennial braindusting to be taken anywhere except in one's own city and state. He, himself, broke down national barriers and recognized the good wherever he saw it, either in men or in their work. He appreciated the virtue of imperturbability and selected equanimity as the title for his first volume of collected essays. He showed the worth of its possession even more eloquently in his life than in his words. In his valedictory address, delivered in Baltimore shortly before he left Johns Hopkins for Oxford, he asserted that a man's best work was done before the age of forty, and

referred humorously to a suggestion made by Trollope in one of his novels that men over sixty should be chloroformed. What he said in jest was taken in earnest! The press of the entire country so heartlessly misrepresented him that he became the target for general abuse. Even then he did not lose his equanimity and those of his own household did not know at the time how keenly he felt the sting of such unjust criticism. About two weeks after the delivery of the address that made his name known to everybody who read a newspaper, he wrote me: "I hope you are hurrying, as the years are flying and you will soon be forty." The following week when I saw him in Baltimore he referred to his experience, but not in a serious way. "It is not pleasant," he said, "to awake in the morning and find yourself, not famous, but infamous." He also remarked that "the way of the joker is hard. I deserve to have been caught long ago."

His jokes were always kindly. He never willingly hurt a brother's feelings, and all men were his brothers. If a stray arrow of wit did cause pain to anyone, he regretted it keenly. He was generous of praise, rarely criticized, and never spoke unkindly. He would never allow anyone to censure in his presence a fellow practitioner of medicine. There was a legend that on the sideboard in the Oslers' dining room there was written in invisible letters this motto: "If you cannot say anything good about a man, say nothing." The admonition "to judge not" he strictly followed. McCrae tells of "the emotional patient to whom he had spoken in a kindly way of the need of self-control. At once the tears began to flow and she exclaimed, with emotion, 'Oh, Dr. Osler, you misjudge me cruelly.' 'Madam,' he replied, with a serious voice, but with a twinkle in his eye, 'Early in life I learned never to judge any woman and that rule I have strictly kept; therefore, I could not have *mis*judged you.'"

His generous aid was extended to all within the medical profession, including some that must have been unworthy. One day I met at the front door of the hospital a shabby old man, a doctor without patients, who was earning money, he said, to

help put his son through a Baltimore medical school by taking subscriptions in advance for a book he was writing. He showed me the list of names he had secured. "There is a man," pointing to the name of Dr. William H. Welch, "who took a copy, although he said he did not practice, and, what do you know, Dr. Osler wants five copies. 'Why, Dr. Osler,' I asked, 'what will you do with five copies?' 'Oh, I want to give them to my friends,' he said."

He had a great regard for what Gladstone called the thrift of time. He did not waste much of it on newspapers or magazines. The speed with which he would skim through a newspaper has stuck in my memory. "Fools were not suffered gladly," as Cushing remarks. Furthermore, he knew how to protect himself from intrusion when he wished to read. Long after my student days in Baltimore, when starting on a two day railroad trip with him from London to the Continent, he gave me a tactful suggestion that he did not care for the casual conversation that leaves two fellow-travelers tired and bored at the end of the day. As we sat down in our compartment before the train left Charing Cross station, he handed me the *London Times*. He then leaned back in his seat, and hid himself behind another copy of the *Times* which he held wide open. A few minutes later, he put down the paper and picked out of his bag material on Thomas Lovell Beddoes, about whom he hoped to write a bio-bibliographical sketch. I took the hint, and kept silent until we reached Dover, busy with my own reading and happy in his companionship. I remember he paused in his reading only long enough to point out interesting features in the hop fields of Kent. So it went throughout the trip. But when meal time came, how different it was! He was then in spirits like a boy let out of school, and his conversation was gay and stimulating. It was chiefly of men and books. I never knew him to be anything but eager to talk about the work of the profession he loved so well.

The following day, soon after luncheon, he spied a distinguished Dutch physician whom he knew walking down the corridor toward our compartment. Now in the nature of things,

this Dutch professor, having discovered Dr. Osler seated in the car, would have stopped, and an afternoon of quiet reading might have been lost. Instantly, on seeing his friend, Osler's sense of the value of time asserted itself, and he sprang forward to greet him before his own identity was discovered, and extended a cordial invitation to come to our compartment at five o'clock for tea. In this way, the afternoon was saved, and a pleasant tea party arranged.

Of his kindness to students much might be said. He had a warm interest in them even when they were unknown to him personally. I remember well my first meeting with him. It was before I had begun clinical studies. One afternoon in Baltimore during vacation, I was reading in the Library of the Medical and Chirurgical Faculty. There was no one in the room except the librarian and myself. Dr. Osler entered and spent a little while looking over the new issues of journals. After chatting a minute with the librarian he left, but, before doing so, he came over to where I was reading and spoke a few words to me; no joke, no epigram, words from him unusually commonplace, but the fact that this great man showed by his manner and act a kindly interest in a strange student made a deep impression on me and warmed my heart.

Before the day of the famous Saturday evening conferences around the big table in the Oslers' dining room, which Boggs has so well described, it was Dr. Osler's custom to invite the fourth-year students, serving as his clinical clerks, to dinner, two at a time. I went with my classmate, Schenck. Being so familiar with two of his earlier essays that I knew them almost word for word, I thought he would probably talk, as he wrote, of Sir Thomas Browne, Plato, and other immortals, who were not of my ken, and I felt ill at ease at the conversational prospect.

But he had the happy faculty of putting everyone at ease instantly. I can see now in my mind's eye, as clearly as if it were yesterday, his entrance into the room. He came quietly, but with a gay air and humming a tune; his hand outstretched. There were no conventional words of greeting, but an inquiry:

"Schenck, what is the name of that pretty nurse who is looking after your patients in Ward F?" There was a common ground of interest after all, and my fears were at once dispelled.

Dr. William S. Thayer, long his senior assistant at Johns Hopkins, and in intimate contact with the Chief, gave a picture of the man at work: "He utilized every minute of his time. Much of his summer vacations went to his studies. On railway, in cab, on his way to and from consultations, in tramway, and in the old bob-tailed car that used to carry us to the hospital, book and pencil were ever in his hand, and wherever he was, the happy thought was caught on the wing and noted down. His ability at a glance to grasp and remember the gist of the article that he read was extraordinary."

Elsewhere Thayer quoted some of Osler's terse statements regarding methods of work. "Observe, record, tabulate, communicate, use your five senses. Medicine is learned by the bedside, not in the classroom. See, and then reason and compare and control. But see first—record that which you have seen; make a note at the time; do not wait. 'The flightly purpose never is o'ertook, unless the deed goes with it.'" This quotation from Macbeth was often on his lips, Cushing tells us. Dr. Osler made as accurate observations at the bedside as he had made earlier in his autopsy work and dictated notes in the wards and in his own consulting room while examining private patients.

He taught the virtue of taciturnity and illustrated its value by an experience of his own which he told us for our benefit. In the early days in Montreal he was once called in consultation by an old physician for whom he had done autopsies. It may well have been the first time he had acted as a consultant and he must have been thrilled. After the examination, Osler was asked to speak to the family. This he did, detailing at length the symptomatology, diagnosis, and prognosis of the case. After they had left the house, the old doctor turned to him and said, "Young man, you talk too much. For forty years I have practiced medicine with a nod of the head."

It was delightful to listen to his brief talks with patients

after he had examined them before the class. Advice was often given in pungent epigrams that must have stuck in the minds of all but the most heedless. To one careless liver, indifferent to his fate, he said, "Remember, Dame Nature gives long credit, but she always sends in her bill."

He conducted his weekly recitations with our small class informally, and often sat on the edge of the table with one leg swinging free. He usually asked few questions; most of the hour being devoted by him to a discussion of various aspects of the assigned topic. The students knew he liked a joke and hence had the temerity to wear sweetpeas in their buttonholes when the exercise dealt with diabetes. When the laugh was on him, which was rarely the case, he didn't rest content until he had the last laugh. One day the subject was the symptoms of chronic nephritis. He began by saying: "Last week we discussed the visual symptoms of chronic interstitial nephritis. There are no auditory symptoms." "Oh, yes, there are," I exclaimed. Silence and amazement followed my rude interruption. Then I said in a tone of triumph, "They are in the book," meaning his textbook, and so they were. The students laughed and one might think the incident would soon be forgotten. Apparently, Dr. Osler scarcely noticed my interruption, but he had a very retentive memory even for the smallest details. Weeks passed when one day he asked me at another recitation to name the diseases of the esophagus. After mentioning cancer and acute inflammation, I, much embarrassed, had to admit that I couldn't think of any others. "You ought to know," he said, and added with emphasis, "They are in the book." And so he had the last word and the last laugh.

He always was most punctual. In the early summer he would begin ward rounds at 8 a. m., and was often in the wards before the students arrived, and sometimes before the house staff. Most of the two hours' visit would be devoted to two or three cases—rarely more than four.

His ward talks were more logical and better planned than

most amphitheatre clinics. One day as the class was leaving the ward a patient in a bed near the door called out, "Good morning, Doc." Doctor Osler made no response to this greeting. When the corridor outside the ward was reached and we were out of the man's hearing, he stopped, and turning to the group of students, who were following him, said: "Beware of the men that call you 'Doc.' They rarely pay their bills."

The hospitality extended at his home in Baltimore, and later in Oxford, was boundless. As Dr. Thayer has said, his wife had a heart as big as his own and made their tea table a mecca. Mrs. Osler told me she never knew how many men he would bring home for luncheon. It might be only two or it might be six. One of the townspeople, amazed at the quantity of food she bought at the market, thought she must be ordering for a hotel!

Living entirely in the present, he was able to preserve his serenity of mind in a way that was most unusual. I chanced to be in Baltimore on the day he left his home at 1 West Franklin Street for the last time, and he invited me to tea. The house was largely dismantled. Packing cases stood in the living room. In a small room in the rear of the house tea was served. Although a carriage was waiting at the door to take him to the station, there was no sign of haste and he talked gaily and interestingly with no apparent thought of the morrow and of the sad fact that he was leaving that home of a thousand happy memories never to return.

The clinical studies made by Osler were nearly all casuistical. He belonged to the group of great nineteenth century English clinicians, headed by Bright and Addison, who were chiefly concerned with the structural changes wrought by disease and their clinical manifestations. Osler was, however, deeply interested in laboratory investigations and in pathological physiology in its relation to the clinic.

Dr. Osler was "a specialized generalist and a generalized specialist" to quote his own designation of Sir Jonathan Hut-

chinson. His clinical interests covered the whole field of internal medicine. He was an acknowledged authority on certain forms of skin disease, especially the erythemas and purpura, and his papers contained much that was new and today can be read with profit. He studied children's diseases and was, possibly, the first to suggest a plan for determining the frequency of tuberculosis in children and the best means of its prevention. He was an excellent neurologist and wrote monographs on the cerebral palsies of children and on chorea, based on cases he had himself studied. In fact, his mastery extended over the whole domain of medicine. A list of his special interests would cover a number of specialties. No one had greater knowledge of typhoid fever and malaria. He was a pioneer in the modern study of diseases of the blood and an authority on heart disease, especially aneurism and acute and subacute endocarditis. To workers in tuberculosis, he seemed especially interested in that disease, and few gastroenterologists studied the diagnosis of abdominal tumors and of cancer of the stomach as thoroughly as this master of medicine. He enriched every subject he touched. Friedrich Müller credits him with giving the first definite clinical description of polycythemia vera and ochronosis, but with characteristic modesty Osler never claimed for himself the discovery of those diseases. Polycythemia he called Vaquez's disease and in his textbook does not mention his own important paper on ochronosis, but does refer to Virchow who reported the first case and described the pathology of the disease.

He established at Baltimore the first clinic in the world in which were combined the one-man system of German clinics and the English plan of clinical clerks and teaching visits in the wards. A salaried resident staff with appointments extending over a number of years was another important innovation in Anglo-American medicine that was of Teutonic origin.

There were no two sides to Sir William Osler. He was always sincere, always charitable, always striving to bring happiness

to others and inspiring others to devote themselves more wholeheartedly to the advancement of the science and the practice of medicine. Many an old pupil feels in regard to him the truth of the verse he quoted when mourning the loss of his old master, Dr. Palmer Howard:

> "Whatever way my days decline,
> I felt and feel, tho' left alone,
> His being working in mine own,
> The footsteps of his life in mine."

PREFACE

WHEN THESE CLINICS were given, Dr. Osler had taught clinical medicine to undergraduate students at The Johns Hopkins only a single year. From the time the hospital opened in May, 1889, until the fall of 1895 he had to content himself with what I have heard him term the " dry husks " of graduate teaching. The first class of third-year students that gathered about him in the academic year 1895-1896 numbered only seventeen. Harvey Cushing points out that it was not until then that Osler's unusual gifts as an inspirer of youth began to be appreciated at their real worth. In control for the first time of a clinic of his own, " his extraordinary talents had full play " (Cushing).

Dr. William H. Welch, the dean of American medicine, wrote that Osler " at the time of his death was probably the greatest figure in the medical world, the best known, the most influential, the most beloved," and that his reputation rested largely upon the inspiring character of his clinical teaching. " I doubt," Welch stated, " whether the history of medicine records a man who had greater influence upon the students who came under his teaching. He inspired them with a remarkable devotion and loyal affection. He was their example. His life embodied his precepts, and his students cherished his words."

The notes that comprise this volume illustrate the truth of this last statement, as they are made up almost entirely of the exact words of the Master. Hence, they reveal the man and his methods of examination. The early clinics were the first instruction in clinical medicine that the members of this second class to enter the school had received, and our knowledge of clinical terms was slight indeed. The first two years of the course had been spent in the laboratories of the preclinical sciences. Dr. Osler referred to us as " medical infants." The class at that time numbered only twenty-five students, but three of these failed to graduate. It was made up of especially

qualified men and women, as The Johns Hopkins was the only medical school at that time to require a college degree and premedical courses in chemistry and physics, as well as a reading knowledge of French and German.

There were two exercises held at noon on Tuesday and Thursday in a room adjoining the medical clinic in the dispensary, a recitation on Saturday, and an amphitheatre clinic at the same hour on Wednesday. The latter was attended by the senior class, as well as by the junior class, while the two dispensary clinics and the so-called recitation which was usually a clinical demonstration were for the juniors alone, the beginners in clinical medicine. There introductory exercises were termed " observation clinics." They were given in a bare room without even a speaker's platform. The students arranged their chairs informally in a semi-circle around a rattan couch for the patient and a plain deal table with Osler sitting beside it. He talked slowly and at times somewhat hesitatingly with a pause between sentences. His deliberate speech made note taking easy.

In turn, two or three patients selected by his assistants, but not previously seen by Dr. Osler, were brought into the room in their street clothes. A history was taken and stress laid upon what could be learned by simple inspection. The clinics presented in this volume have been well described by Walter R. Steiner, a member of our class, in his presidential address before the American Clinical and Climatological Association, as follows: " On these occasions he acted as a fellow student with us, guiding us in our examinations of the patient, causing us to see what we had not previously noted, and making us realize that the Hippocratic dictum, ' to see, to touch and to hear,' was not all in making a diagnosis, for Laennec introduced the words, ' to auscult ' and so revealed further facts. But he showed us that all this went for naught if we did not follow what Louis, the great French clinician, had taught us, ' to record.' "

From the outset he emphasized the historical aspects of medi-

cine and the importance of reading the original works of contributors to medical progress. He advised us to read the old books of the masters of medicine and the present-day journals, leaving the new books to older men. He assigned topics to the students and asked them to read up the literature and prepare five-minute papers which were presented at subsequent meetings. For example, when in a recitation I stated that I would give Blaud's pills in anemia, he asked me, " Who was Blaud? " When I replied that I did not know, he said, " Look him up." This led to a visit to Dr. Welch and a search through his library and finally to the Surgeon-General's Library in Washington. A list of other topics assigned by Dr. Osler will be found in the index of subjects under " reports " by students.

The weekly amphitheater clinics, as Steiner stated, " were of great interest and in them we, as third and fourth year students, chiefly considered typhoid fever and pneumonia. Dr. Osler used to say if we knew typhoid and its complications we would have a very fair knowledge of medicine, and the numerous complications which were afforded us in our study of typhoid at The Johns Hopkins Hospital were really a mine of information." A glance at the index of this volume under the heading " typhoid fever " will show the correctness of this statement. Data on all the cases of typhoid fever and pneumonia that occurred during the year, and many of the patients, were presented to the students.

The reader of these notes will note the humility of the teacher and his willingness, even his eagerness, to acknowledge his mistakes in diagnoses; witness the two cases of acute pulmonary tuberculosis, first diagnosed as lobar pneumonia, and the patient with unrecognized scarlet fever, in whom the diagnosis was made only when a second case occurred in the patient's home and another in the same ward in which he had occupied a bed.

His spoken words, like his writing, had " a Gallic clarity of style." " They were," as George Blumer has said, " terse, pithy and pregnant with the wisdom of ripe experience."

Although these clinical lectures and demonstrations were given fifty years ago, they possess their original freshness in large measure and contain much of value to the physicians and students of today. They show how much can be learned at the bedside by the inquiring mind, the seeing eye, and the trained hand, even without the aid of modern laboratory methods.

PLATE 1. DR. OSLER AND DR. HURD WITH THE MEMBERS OF THE CLASS OF 1898, JOHNS HOPKINS MEDICAL SCHOOL.

Left to right. Standing—Arthur W. Elting, J. Daniel Madison, Walter R. Steiner, Georgiana Sands, J. H. Mason Knox, Emma E. Walker, Katherine Porter, Benjamin R. Schenck, Frank A. Lupton, Alfred B. Herrick, Mary S. Johnstone, Gertrude A. Light, William W. Ford, Harry T. Marshall, Percy M. Dawson, John W. Coe, Thomas W. Hastings, Delia O'Connell, William S. Baer, Joseph H. Pratt.

Seated—Walter Cox, Dr. Osler, Dr. Henry M. Hurd, Patrick J. Cassidy.

(Photograph furnished by Dr. J H M Knox)

PLATE 2 DR OSLER EXAMINING THE CLINICAL RECORD AT THE BEDSIDE OF A PATIENT.

(Photograph taken by Dr Charles K Winne, Jr.)

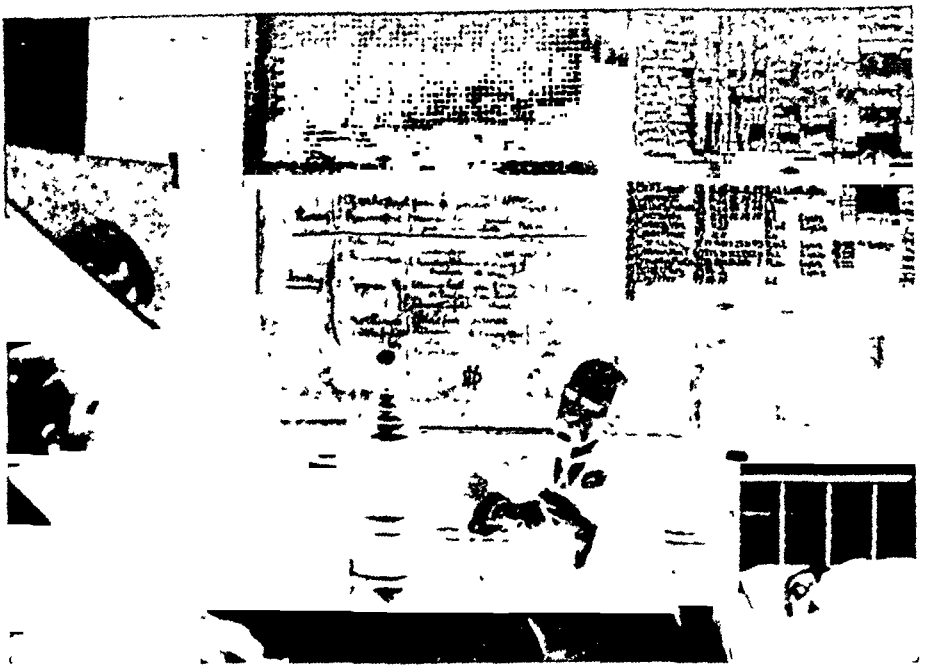

PLATE 3. Dr. Osler questioning a student at the amphitheater weekly clinic for the third- and fourth-year classes. Records of the year's pneumonia cases are on the blackboard.

(*Photograph furnished by Dr. W. W. Francis*)

PLATE 4. Dr. Osler seated at his desk in the Dispensary while holding an Observation Clinic for the third-year class.

(*Photograph taken by Dr. Charles K. Winne, Jr.*)

Jan 6. 1897 - Amphitheatre Clinic - Dr. Osler.

CHLOROSIS p. 91, 99. 140

Kate Schultze - When admitted haem. at 30% and r. b. c. at 40%. She has been treated (1) good food (2) rest in bed. There has been a steady ascent in r. b. c. now reach 90%. The haem. has not gone above 40% It is still a typical case of chlorosis. She has been treated for five weeks. Now iron will be given. In the dispensary several cases cured recently by iron alone, without rest in bed or better food. This case shows that cure at times cannot be effected without administration of iron

TYPHOID FEVER FATAL CASE p. 100, 110.

Herring - On 27. temp. high 104° At 4. P.M. pulse 130 a bath was given, did not take this well so removed. He died next morning. He was in hospital 19 days. Autopsy showed c.s. of kidney, liver, and heart Healed ulcers, Pulmonary oedema.

TYPHOID FEVER DEATH FROM HEMORRHAGE.

Henry Lee - 26 yrs. Admitted Dec. 28. He was taken ill three weeks before. On admission dull, walls of intestine tender. Rose spots developed. Dicrotic pulse. Vomiting once. On Dec 31 had a liquid Stool blood-stained - no effect on temp. Later two bloody stools - the second one was 200 c.c. pure blood. This was followed by drop in temp. He seemed to die directly from the haem.

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PLATE 5. SAMPLE PAGE OF THE ORIGINAL NOTES.

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ILLUSTRATIONS

DISPENSARY CLINIC

October 6, 1896 — Dr. Osler

Anamnestics—a word used much in Germany for the personal history.
Diagnostics—the art of diagnosis, i. e., discrimination.
Prognosis—judgment regarding future progress and termination of any disease.
Therapeutics—treatment.

Gee's book on auscultation and percussion is recommended. The historical development of the subject is very satisfactorily presented in this book. Auenbrugger was the discoverer of percussion. His treatise is very difficult to obtain. Laennec was the first great modern clinician. His work was published in 1818. The best edition in English is Forbes'. We owe a great debt to Laennec for advancing knowledge of the abdominal viscera as well as of the lungs and heart. Buy any edition that you find on sale. Skoda, the Vienna physician, next to Laennec, was the great developer of auscultation. His book, *Auscultation and Percussion*, is a good one to pick up in old bookstores. Von Jaksch's book, *Klinische Diagnostik*, is admirable. The illustrations are especially good. It has an excellent account of the malarial parasite. Until recently Germans have known nothing of malaria. Simon's *Clinical Diagnosis* is very good. The section on the urine is excellent; perhaps the best in English.

The first two chapters in Musser's *Diagnosis* are assigned for the recitation on Saturday.

It is always valuable to note the *occupation* of a patient. It may point to the diagnosis of the disease. The fact that a man with anomalous symptoms and a cutaneous eruption is a wool sorter may give the diagnosis of anthrax. Glanders is associated with workers in stables. It is very useful to know this in obscure cases. Lead workers, painters, and users of lead are liable to diseases which are recognizable when we know the occupation. When a man with extreme pallor says he is a

painter, this fact at once points to lead poisoning as the cause. The same with tailors as there is lead in the thread they use. Oystermen here are much affected with malaria.

It is important to note the patient's race, whether native Americans, Colored, Germans, Poles, Bohemians, Slavs, etc., because certain diseases are more prevalent in some races than in others. Colored persons are more disposed to tuberculosis than white. This may be due to the unhygienic conditions in which they live or to increased susceptibility. There are diseases brought here from foreign countries. A tapeworm in a Lithuanian is apt to be *Bothriocephalus*. Icelanders are liable to *Echinococcus*. This causes hydatid disease of the liver. The hospital in Manitoba has more cases than all the rest of the country together.

Age should be put down carefully. In early childhood there is a greater liability to digestive disorders (gastro-intestinal disorders) and fevers. Physiological processes, such as dentition in children, produce symptoms.

Sex. Chlorosis is very rare in men; extremely common in women. Men are more liable to early degeneration of the vascular system. This is associated with: (1) harder work, (2) more alcohol, (3) greater liability to syphilis. Disease of the mitral valve attacks women more frequently than men. There are six cases of aortic lesions in men to one in women. Nervous diseases of the degenerative type, and apoplexy, are more common in men.

A patient in street dress was brought into the classroom from the Medical Clinic of the Dispensary.

Ask the man of what he complains. Put that down as he describes it in his own words. Then take the history. Begin with the family history. Ask of what diseases did the parents die. In the case today there is nothing in particular in the family history except that the mother died of heart disease. He does not know the cause of his father's death. This patient had chronic diarrhea when young. He had yellow fever and malaria when he resided in the West Indies for 13 months. All patients say they have had "rheumatism." Inquire more par-

ticularly: "Were you in bed? Were the joints swollen and red?" You can put down "rheumatic pains" when the description is vague.

It is most important and most difficult to get a history of syphilis.

This man has an interesting past history. He was ill for 3 months in bed. It is difficult to say whether he had inflammatory rheumatism or not. Put it down with a question mark. He has not used tobacco or alcohol, except a glass of beer every two months. It is a good history. Now inquire about his present trouble. He has had "rheumatism" in the ankles for the last year, and shortness of breath the last 7 months. Now take up questions of habit. It is often better to inquire of relatives. It is often well to ask: "How many times a day do you drink?" A man who drinks before breakfast as a rule is a heavy drinker. This is not true south of Mason and Dixon's line. There a man may take his only drink before breakfast. But it is well to ask, "When do you take your first drink?"

Shortness of breath is a symptom of heart trouble more frequently than of lung disease.

Examination of the patient by inspection. Look at his gait as he enters the room. The diagnosis may rest on the first glance, as in an advanced case of locomotor ataxia. This patient sits in an easy position. His face is slightly flushed. There is no pallor. His finger nails show a blushing action at each systole. This is a capillary pulse. There is here an excessive grade of visible pulsation. This points to a form of heart disease. Dr. Osler was impressed at once by the pulsation of the right temporal artery.

First note the position patients assume before they have been disturbed. Then the inspection should be made very thoroughly and systematically. The diagnosis often rests on inspection; for example, in hemiplegia, myxoedema, spastic paralysis, and acromegaly. Two cases of acromegaly have been seen here in Baltimore. In this disease the features and extremities are greatly enlarged. The first case on this continent was diagnosed in Toronto.

Vascular throbbing just as great as in this case may occur in exophthalmic goitre, neurasthenia, and anemia.

AMPHITHEATER CLINIC

OCTOBER 7, 1896 — DR. OSLER

Chills in Typhoid Fever

Case I. This patient came in at the end of the third week of the disease. The attack was complicated by multiple erythema. This occurred over the joints in different parts of the body and lasted for a long time. After the 70th day, chills developed with paroxysms of fever. Several chills (5 or 6) occurred between this and the 80th day. Now this is the 102nd day. On the 90th day his temperature became normal. Last year we had several cases with chills.

Chills occur

(a) at onset;
(b) at onset of relapse;
(c) at onset of complications (pneumonia);
(d) as a result of drugs. This is frequent after the use of antipyretics. See paper in The Johns Hopkins Hospital Reports, Volume V.
(e) in septic complications. Many cases of typhoid fever are not pure infections; septic micro-organisms are often present.
(f) when malaria coexists. Chills may be due to a combined infection. This is very rare. Here in 500 cases of typhoid fever there was none in which typhoid fever and malaria was concurrent. Many practitioners mistake the chills in (d) and (e) for malaria.

This is a case of chills with no signs. The chills have been severe and the pulse high, but the prognosis is favorable as no pleurisy and no signs of other complications have developed.

Last year a patient of this type with even higher fever recovered.

Chills are often due to thrombi in veins, infarcts in the spleen or small abscesses in the kidney.

Case II. The first chill was on August 17. On August 19, the leg was much swollen. On August 24 the temperature rose rapidly. A thrombus developed in the internal saphenous vein. The leg now is much swollen and oedematous. It is red and tender. We have here phlegmasia rubrum dolens. The chill on the 17th seems to have preceded the formation of the thrombus. The outlook is now good. Bandage lightly from ankle to knee now, and apply friction morning and evening with lanoline or cocoa butter.

His temperature despite baths remained very steady (105°-104°). The diurnal variation was slight, only 1° to 1.5°. No other disease shows this steady fever except pneumonia. Apyrexia does not always separate the period of fever from that of the relapse. Here we had a relapse without apyrexia; after 8 days of low temperature, the fever rose from 105° to 107°. There are only a few cases in our hospital records of so high a temperature in typhoid fever. In the last Johns Hopkins Hospital Reports, Volume V, is recorded a long series of cases with relapse without apyrexia.

This year there have been 30 cases of typhoid fever in the hospital and none with diarrhea.

Malaria With Nephritis

Case I. This patient is a girl of 9 years. Her illness began with dropsy. She was admitted on September 9th; the duration was then 1 week. The child was pallid. There was anasarca. This case was of very short duration, 1 week, for so general an oedema. The urine was scanty and bloody. It contained a large amount of albumin and casts. Chills are not common in connection with acute nephritis. This made us suspicious. The blood condition gave us at once the cue; as hyaline bodies in small numbers were found in the blood. The

acute nephritis and haematuria were due to the malarial poison. Malaria with nephritis is not common in this latitude, but further south malarial haematuria is very common. See Dr. Joseph Jones: *Medical Memoirs, Volume II.*

Dropsy occurs in malaria in

(a) acute malarial nephritis;

(b) chronic malarial nephritis. See Barker, Case I, *Johns Hopkins Hospital Reports, Volume V.*

(c) malarial cachexia.

In 1892 a case of malarial nephritis was observed here in the hospital. It was very severe. The examination of the blood is all-important. The case in 1892 could probably have been saved if an immediate blood examination had been made. The organisms are often so scanty that careful examination is required to detect them. They may be scanty in the blood and yet abundant in the organs.

Case II is of interest. Illness began on the 15th of September. He was admitted the 25th of September, with pains in back but no distinct chills. Anasarca was present. It was a case of acute malarial infection with nephritis. The patient died on the thirteenth day of illness with uraemic coma.

Pernicious Malaria

Case III. Illness began two months ago. Chills occurred every other day. The patient came from a very malarial locality. He was almost comatose when admitted, and could not speak. There were spasms in his left arm. His head was drawn to one side.

Comatose symptoms may occur early or late. A patient may die in coma within 24 hours of onset if he lives in a malarial region. This case was the other type; namely, chronic malarial fever with coma. The brain at autopsy has been found *lead colored and containing many organisms.* See Councilman and Abbott, *Transactions of the Association of American Physi-*

cians, Volume I. In these cases there is a persistent low temperature 95°-96°.

When patients are admitted with anaemia and a low temperature, we are always suspicious of malaria. No other condition gives such a temperature chart.

There is a slough on the arm the size of a quarter. This may be due to: (1) the burn of a hot water bag; (2) hypodermics of digitalis or quinine.

DISPENSARY CLINIC

October 8, 1896 — Dr. Osler

Heberden's Nodes

This woman complains of tender nodules on the distal phalanges of her fingers. They are unusual. She never had rheumatism but has had some creaking of the joints and some dyspepsia. Two little nodes are seen at the end of the second phalanx upon the normal bone. These nodes enlarge after middle life. They are more common in women than men. They are tender at first; later ankylosis results. They are called nodi digitorum or *Heberden's nodes.* Heberden lived in the middle of the last century. The nodes are described in his *Commentaries.* The nodes are exostoses; rarely, if ever, chalk stones as commonly described, but true bone. Not all bone, as the soft parts are also affected. They occur particularly in gouty families but are not the nature of gout. They are common in this country; gout is rare here. This patient has no chalk stones in her ears. The nodes are incurable. Reassure patients by telling them that other joints will not be affected. The swelling of the soft parts goes but not the exostosis. They are found in people with dyspepsia; usually acid dyspepsia. They are often called " gouty fingers " but this is an error. Chalk stones are a manifestation of gout and are called tophi. These nodes are the mildest manifestation of rheumatoid arthritis or arthritis deformans.

Typhoid Fever

Case III. Robert Kuhn, aged 21. It is important to get the exact address of a patient "What is your occupation?" He is a butcher. He complains of headache, weakness and fever. Put down the complaints as far as possible in the patient's own words. How long have you been sick? Not well since August. A week ago Tuesday gave up work." *It is important to note the day a patient gives up work.* Always put it down. If you put down the day of the week, *always add the day of the month.* No nose bleeding. He has been sick to the stomach and has had diarrhoea. He has quite a fever so inquire if others in his house are sick.

The patient has a furred tongue. The fungiform papillae stand out plainly in the front of the tongue. The pulse is 120. There is visible pulsation in radials and ulnas; the superficial veins are very full. There is a well-marked capillary pulse, as with each systole the finger nails blush. In this condition, a pulsation due to the cardiac systole is often also seen in the superficial veins.

Diagnosis. Has the patient a local disease? The symptoms,—fever, headache, etc.,—might be due to a slight tonsillitis. So look at his throat. The pharynx is red but the tonsils are normal. The fever most common here in Baltimore, especially in the fall, is malaria. His blood examination is normal. The duration, the history, up one day down the next, the prostration now, all point to typhoid fever.

The abdomen is flat. Estimate the temperature by feeling the abdomen with your hand. This is a good practice. The spleen is not normally palpable. In this case the edge of the spleen on inspiration is felt below the costal border.

Look for rose spots. They are due to hyperaemia; not to hemorrhage. The capillaries are simply filled with blood; there are no extravasations. Rose spots are most marked usually on the abdomen but often numerous over the back. Several spots are seen in this case. The temperature on admission was normal. Half an hour afterwards it was 103° A low tempera-

ture is a frequent occurrence after exposure. He had walked a long time in the cold and almost had a chill.

The symptoms are very suggestive of typhoid fever but anomalous malaria might produce similar symptoms. But this man was not as pale as he would have been if he had malaria, and his spleen is not as large as it would have been if he had malaria for two months. The spleen here is only slightly enlarged.

DISPENSARY CLINIC

OCTOBER 9, 1896 — DR. OSLER

Arthritis deformans is the same as ring bone in the horse. Gout deposits are urates; "chalk stones." Eponymic disease and symptoms are named for some person. For example, Heberden's nodes on the fingers are named for William Heberden, the distinguished English physician who first described them. They are sometimes mistaken for gout. The gout deposits may ulcerate and the patients have been able to write upon the blackboard with the diseased joints. Look up Heberden. Look in the Index Catalogue of the Surgeon General's Library.

Fever

The patient is brought in. Take the temperature. The normal temperature is about 98°. The highest available is in the rectum. It is about 2° lower in the axilla. The diurnal variation is about a degree and may be less. The temperature falls in the early morning hours; being lowest from 3 to 5 a. m. There is a slow rise toward noon. Between 4 and 5 p. m. the maximum is reached.

Persons in not very good health, who are not robust, may have a very low morning temperature; perhaps not more than 97°. This may account for the miserable feelings of these people in the early morning.

We saw on Wednesday a case of very low temperature in malaria. This was remarkable. It occurs in certain types of

chronic malaria and is very suggestive in itself. A low temperature occurs in some forms of chronic tuberculosis; the lowest in those with hectic fevers, in the late septic state, and in septicaemia and pyaemia. In these cases the temperature, in 10 hours of the 24, is below normal. In patients brought in drunk after exposure, the temperature is often very low. In typhoid fever patients, who have been waiting in the cold the temperature often first registers below normal. In uraemic poisoning and opium poisoning, subnormal temperatures occur. During convalescence from typhoid fever, the temperature is often subnormal.

This patient's temperature is 101.5°. This is a slight fever. Above 107° we call it hyperpyrexia. This is rare. In rheumatic fever and typhoid fever, the temperature may run very high. But in typhoid fever in 500 cases none was above 108°. Tetanus more often than any other infection has a fever as high as 110°-112°. Certain injuries of the nervous system, involving the brain and spinal cord are followed by high temperatures. Paradoxical temperature is chiefly seen in hysterical women; occasionally in hysterical men. Temperatures of 110°, 120°, 140°, and 180°, have been reported by doctors. The majority of these temperatures are fraudulent; the result of a deception on the part of the patient. The latest case and the most wonderful, was recorded by Dr. Jacobi in the last volume (1895) of the *Transactions of the Association of American Physicians*. Read it. The Omaha case quoted by Dr. Welch was published in the *American Journal of the Medical Sciences*. In this the temperature was 170°. Some are fakes; some genuine. The latter follow injuries. These latest cases just cited were deceptions.

In this case here, notice if the fever is continuous, intermittent or remittent. In the remittent type, there are distinct remissions each day but not distinct intermissions. In intermittent fever, periods of pyrexia are separated by days of apyrexia. It is a pity that intermittent fever is synonymous with malarial fever. The fever of septicaemia and early tuberculosis is also intermittent. The temperature is ordinarily taken

twice a day. In fevers it should be recorded every 3 hours, and in typhoid fever every 2 hours. In private practice it is rarely necessary to take the temperature so often. A chill precedes intermittent fever more frequently than any other fever. The paroxysm extends from the first appearance of the chill to the end of the period of fever. At the beginning of the chill the patient is usually febrile.

This girl is anaemic. She has chills every other day. Read the chapter in *Musser* on fevers and the description of the malarial parasite in Thayer and Hewetson's article.

DISPENSARY CLINIC

OCTOBER 13, 1896 — DR. OSLER

Heberden was born in 1710 and died in 1801. Buller wrote his life. Heberden's "Commentaries" are celebrated. In these he describes his nodes and angina pectoris. He was the first to describe angina pectoris.

Types of Fever

A chart of intermittent fever was shown. The febrile period is called the paroxysm. It consists of three stages: (1) chill; (2) rise in temperature; (3) sweat. The chill is not always present. Early in the chill the temperature is elevated as a rule. With the quotidian form of malarial fever there is a paroxysm every 24 hours. A chart is shown in which the paroxysm lasted from 10 a.m. to 10 p.m. Fever rose until 4 p.m., then fell until 10 p.m. That of another case is shown in which the paroxysm lasted just 12 hours. In tertian fever there is a full 48 hours interval between paroxysms and a full 72 hours in the quartan type. The last is very rare. Tertian fever is the most common. A chart of remittent fever is shown. There were marked drops in temperature during remissions. In the great majority of fevers there are remissions that follow the diurnal change. A chart of a continued fever is shown. The maximum was 105°; the lowest 104° in 24 hours. Many

of us have a greater remission than that. This chart is of a case in the early stage of typhoid fever. A chart of subnormal temperature is exhibited. It shows a maximum of 96.5°. We rarely get a temperature lower than this. In the intermittent fever of tuberculosis, the dip below the normal line may be as great as the rise above the normal. A subnormal temperature in malaria is common. The case of chronic malaria shown last Wednesday had this chart. The low temperature points to the diagnosis.

There are three periods in the paroxysm of fever: (1) stage of ascent; (2) period of maximum fever called the fastigium, a Latin word meaning ridge, the highest point; (3) period of decline. In typhoid fever the ascent usually continues for 4 to 5 days; the fastigium a week or two. The decline lasts from several days to a week or more. The period of ascent may be very abrupt or gradual. The fastigium may be reached in 2 hours or it may take a week. In typhoid fever the fastigium may last from several hours to several weeks. The period of decline may be slow or very rapid. A slow decline is termed a lysis. A rapid fall is called a crisis. In pneumonia the fever terminates by crisis. For example, the temperature today may be 105°, 12 hours later it may drop to 97°. In typhoid fever the fall is gradual, step by step, usually taking a week or more. The phenomena of fever are best studied in the malarial paroxysm. *It is an epitome of all fevers.* First, there occurs the curious sensation of uneasiness that is not localized but diffuse and not easy to describe. It is due probably to the effect of the rise of even one degree upon protoplasm. Then a creepy sensation occurs. Aching pains develop in the back and legs. The head aches. These symptoms are the same in all fevers, but vary in degree. They are called prodromes or prodromal signs. In intermittent fever there is a positive shake; a rigor. The skin feels cold; goose skin with its puckered appearance develops and the teeth chatter. Sometimes the shaking is of extraordinary violence. The tremor can be communicated to the bed. The teeth chatter audibly and violently. The finger tips are blue. The chill lasts from a few minutes to a

half hour or an hour or even longer. There are cases of malaria in which the patients are in a persistent state of chill. The skin is blue, the temperature subnormal. This is the " algid " type of malaria. At the end of the chill the patients feel more comfortable and the blueness disappears. Now the patients say they begin to feel hot. The pulse becomes fuller. The cutis anserina disappears. The superficial vessels fill with blood. The patient soon begins to feel burning hot. In half an hour he may be as red as a beet. The pulse becomes full and bounding, as if he had been in a hot bath for 20 minutes. Then begins the bursting splitting headache. Each throb of the heart is felt in the head. This stage may last a variable period; that is from 2 to 3 hours. It ends by the patient feeling a little moisture on the skin. He begins to feel it on the chest and in the arm pits, then on the forehead. In half an hour he is in a drenching sweat. Sweating begins just at the end of the fastigium. The sweat lasts from an half an hour to two hours. When the temperature reaches normal the paroxysm is over. In all clinical observation no such change occurs as that in malarial fever from the furious discomfort of the height of fastigium to the feeling of repose and well-being at the end of the paroxysm six hours later.

" Critical discharges " were formerly thought to be of great importance; namely, sweating, a diarrhoea, the voiding of large amount of urine, etc.

DISPENSARY CLINIC

October 15, 1896 — Dr. Osler

William Heberden, physician and Latin scholar, is frequently confounded with his father. It was the elder who described angina pectoris and the nodes on the fingers. Angina pectoris is a disease characterized by agonizing pain over the heart and a feeling of impending dissolution.

The case of a negro showing the arcus senilis is demonstrated. It is a ring of fatty degeneration in the periphery of the cornea.

This is a very pearly white arcus senilis. O. W. Holmes called it the " old man's spectacles."

Mitral Insufficiency

Male—62 years. He complains of asthma and palpitation. His first attack of asthma occurred 18 years ago. His health has been good. He had measles with nose bleeding. He had persistent recurrent epistaxis, beginning as a child which lasted for 30 years. Then it ceased and has not recurred. This long-continued bleeding from the nose is remarkable. We had a similar case in the private wards. There were marked varicosities in the septum which were cauterized. There has been no bleeding since. In the present case the bleeding was probably associated with dilated venules of the mucous membrane. He evidently did not have asthma as a young man. He says he has not had the " bad disorder " but on further questioning, thinks he has had syphilis.

Physical Examination. He looks a little pale. There are no tophi in the ears. The hands are congested and somewhat livid. There is no shortness of breath now. Take the pulse after the patient has been seated a little while, before asking him to get up and take off his coat. The pulse here is intermittent and varies in force and fullness. It is 108 to the minute. The abdomen is distended. The foot and leg are much swollen. The skin is rough and reddened. This condition of the leg might be due to (a) oedema, (b) fat, or (c) elephantiasis. The last is a thickening of the skin and subcutaneous tissues due to inflammation and obstruction of lymphatics. The skin of this man's leg pits on pressure, hence, the swelling is caused by oedema.

He has an old man's chest. It is prominent anteriorly and somewhat barrel-shaped. The breathing is more an elevation than an expansion of the chest. This is due to calcification of the costal cartilages. The suprasternal notch is very deep. He is emaciated. The cardiac impulse is 2 cm. outside the nipple line. There are no thrills. A loud systolic murmur is present.

He is a healthy looking man for his age. The Bardolph's venules upon the nose are of no significance at his time of life. They are met with in beer drinkers and dyspeptics. There is no arcus senilis. That is a white rim in the cornea at the junction with the sclera. There is no dyspnoea. The pulse is quiet—85. The radial arteries are visible. The temporals are quite plainly seen. There is visible pulsation in the radial arteries. The recurrent or anastomotic pulse is seen in the radial after compressing it above. This is not due to inability to compress the radial artery but to an anastomosis through the ulna. Upon compressing the ulna, the radial pulse ceases entirely. The wall of the radial artery is a little stiff. He has had no attack from tying his shoe, or in dressing, or from exposure to cold. On inspection of the chest, the apex beat is not visible. There is no marked precordial throbbing. The heart sounds are clear at apex and base. The second aortic sound is much accentuated. There is no visible pulsation in the vessels in the neck. There are no tophi in the ears (urate of sodium), and the joints are not enlarged.

Here is a man who has been healthy all his life. He has been a hard worker. Two years ago he had his first attack of shortness of breath and pain in the left arm. The attacks come on suddenly. He turns pale before and during attacks.

This is an illustration of an interesting disease. It is angina pectoris, or stenocardia. In 1769 it was first described by Heberden. It is very rare in hospital practice. It is characterized by agonizing pain in the region of the heart and cramps in the left arm. The feelings vary from discomfort to agonizing sensations. There may be a terrible substernal pressure (dolor pectoris). Mental symptoms may be present. There is usually a feeling of impending death (angor animi), Vaso-motor phenomena occur producing paleness. The patient may even faint. The disease develops after the middle period of life. It may follow syphilis. A patient may die in his first attack as did Arnold of Rugby. John Hunter in 1793 died in his 20th attack from a fit of anger. Sudden death follows in a large percentage of cases. This man may die as he walks down the hill. He has

not had the agonizing paroxysms. Immobility is a characteristic feature of the seizures. He, however, has some power of motion during the attacks. There is no doubt he has angina pectoris. Many of the sudden deaths you read of in healthy, vigorous men, especially at night, are due to angina pectoris. An autopsy reveals sclerosis of the coronary arteries in most cases. The pathology of angina pectoris is not well known.

Intermittent claudication is a disease of horses. They have as a rule verminous aneurisms with narrowing of the lumen of the abdominal aorta or external iliacs. In trotting the horse fast not enough blood passes through the narrowed lumen to supply the muscles of the hind legs. He may be able to walk well, but in trotting the horse an ischemic condition of the hind legs comes on with resulting loss of power. It is supposed that in angina pectoris the lumen of one coronary artery is narrowed. When the heart is beating with ordinary force, slowly, enough blood reaches it to keep up its nutrition. After exertion, there is a relative ischemia of the heart muscle associated with paralysis or spasm of the heart. This theory was first broached by Allan Burns of Glasgow in 1809. It is a very pretty theory.

John Hunter lasted 20 years. The day of his death he dissected three hours. Matthew Arnold, his father, and grandfather died of this disease. It is exceedingly rare for it to occur in three generations.

AMPHITHEATRE CLINIC

October 14, 1896 — Dr. Osler

Hemorrhage in Typhoid Fever

Twenty cases of hemorrhage of the bowels occurred in our series of 389 cases of typhoid fever. Four died directly from hemorrhage; several of perforation. The hemorrhage comes from erosion of vessels in the ulcerated areas in Peyer's patches. Slight hemorrhage may occur from oozing of congested vessels. The amount of blood lost in a hemorrhage may be very considerable. In rare instances the patient dies before any blood

is passed. One case occurred here with death in three hours in which no blood was passed, but at autopsy the large intestine was found full of blood.

Signs: The patient turns pale. The pallor is partly a vasomotor phenomenon. Sweating occurs. Restlessness that goes with losses of blood develops. The temperature falls and the patient is cool. In three hours or so the temperature may be subnormal.

Case IV. Death From Hemorrhage in Typhoid Fever

This was our first fatality. Dangerous hemorrhage is always attended with a fall of temperature. This patient's temperature became normal on the 16th day. On the 18th and 19th day there was a gradual rise and a relapse occurred. It was ushered in with retention of urine. The temperature rose gradually to 105°. Even on the 6th and 7th day of his relapse he was not seriously ill. There was no delirium. On October 30 he was in a satisfactory condition. At 4 p.m. he had a large bloody movement consisting of 600 cc. of pure blood; another at 7 p.m. The temperature dropped between 4 and 6 p.m. from nearly 102° to 96°. Collapse persisted throughout the night. There was no further hemorrhage. 1500 cc. of salt solution were infused beneath the skin. The next morning blood was infused. He died at 4:30 p.m. He lost altogether 1200 cc. This was not enough to produce death. He was a full-blooded man. But probably much blood remained in the intestine. He never rallied well. The pulse the morning following the hemorrhage was hardly perceptible. This accident cannot be guarded against. We never know when to expect it.

Case V. Hemorrhage in Typhoid Fever

A tarry stool was passed around the class in a bed pan. The clots were plainly seen. The patient was a young man of twenty-eight.

Treatment.

(1) Opium: a) lead and laudanum; b) lead and opium pills.

(2) Ice bag over ileum.

This man had two copious hemorrhages, one at seven, another at eight. They did not reduce the temperature however. This is always a good sign. He has had no recurrence of hemorrhage. He is doing well. In a few days we will resume the baths.

In a large hemorrhage from large vessels *rest is the chief treatment.* The hemorrhages that kill are from *good-sized arteries.* Use measures to keep the clot in position at the base of the ulcer.

Case VI. Typhoid Fever Complicated by Diphtheria

Man, aged 22. Admitted the 9th day of illness. Temperature ran between 102° and 104°. He was doing well. On the 17th day a raised patch was seen on the lip. The membrane was easily removable, leaving a raw not bleeding surface, upon the inner side of the lip. It looked like an ordinary croup membrane, but cultures showed Klebs-Loeffler bacilli. Antitoxin was given and within a short time the temperature fell from 103° to 101°. There was no membrane on the throat.

This is a very mild case of what may be a dangerous complication. Diphtheritic membranes may occur in the mouth or in the throat. There were 2 or 3 fatal cases of faucial diphtheria in typhoid fever while Dr. Osler was in Montreal. The membrane may occur in the larynx and even in the bladder, or in the pelves of the kidneys. The membranous exudation may be due to the streptococcus sometimes as well as to the Klebs-Loeffler bacilli. See Langenbeck's *Archiv,* Vol. 21 or 31, for a very elaborate article on this subject, the diphtheritic complications in typhoid fever.

Case VII. Typhoid Fever with Decubitus

On admission the patient had a distinct excoriation on the back. A deep extensive slough came away. It was over the sacrum and was unusually deep, measuring 2 to 3 cm. It is now healing well. On each heel is an excoriation consisting of superficial necrosis of the skin and subcutaneous tissue. This is the only case of bed sores in the house out of 32 typhoid patients. They occur on the heel; just where the pressure was persistent.

The patients should not be allowed to remain too long in one position; especially when debilitated and very ill, as they lie for hours without moving, and the weight of the body pressing on the same parts continually gives rise to these bed sores.

Malarial Fever

Both patients shown last week are doing well.

We have two totally different types of intermittent fever: (a) the regular intermittent seen in the spring; (b) the irregular in which paroxysms do not come on regularly. The fever may be continuous or the paroxysms may last 24 to 48 hours. The fever may be remittent. This type is called, especially in southern parts of the country, gastric and bilious fever owing to the prominent gastric symptoms and jaundice. In the irregular fevers the malarial organisms are not well distributed in the superficial blood vessels. Councilman in 1886, by tapping the spleen, showed they were abundant in the internal organs.

Malaria Mistaken for Typhoid Fever

The patient when admitted complained of headache and malaise. No epistaxis; no marked chill at onset. Marked vertigo. No rose spots. Blood examination negative. No leucocytosis. He was bathed persistently. The baths did not reduce his temperature. The spleen was still plainly palpable. The chart was typical of remittent fever. The temperature fell 5 degrees in one day from 105° to 100°. It is a very unusual chart for typhoid fever. In typhoid fever there are fewer re-

missions in the first 12 days than in any other fever. On the 9th day hyaline bodies were found in his blood. The enlargement of the spleen is not so great in the chronic remittent fevers as in acute intermittent. There was a slight yellow tinge to the skin. This made us suspicious of malaria. These pernicious types resist quinine to a marked degree. It must be given persistently. The temperature is now normal. He has taken 150 grains to date. He began to take quinine five days ago.

The man shown last week with collapse but no chills was a case of the chronic type. In this class of cases the malarial organisms are driven out of the blood only with difficulty. In this man today the malarial organisms yielded readily to quinine. This man, if left alone, in 10 days would have a very large spleen. The blood would contain pigmented leucocytes; the anaemia would be marked and the diagnosis would have been plain.

DISPENSARY CLINIC

October 20, 1896 — Dr. Osler

The causes of epistaxis not associated with hemophilia were discussed. The case in the hospital was due to varicosities on the septum of the nose. It was cured by cauterizing the vessels.

Arcus senilis is called in German *Gerontoxon*,—old man's bow.

The old man with heart disease examined last Thursday, October 15, came into the hospital that day. He was very much cyanosed. His face was suffused. Now he is a different looking man; his facies are entirely changed. The swelling of his feet has disappeared and there is no longer fluid in the abdomen. The apex beat is now in the fifth interspace and the murmur in the apex region is not nearly so loud. In fact, it is now very soft. The sounds at the base are clear.

When first seen here five days ago, he had failure of compensation. Now the equality of his circulation has been restored. If he had remained at home and been up and about

he would have been dead in two weeks. His good condition is due to two things: (1) He has had quiet in bed with a purge; in this case sufficient treatment. (2) Digitalis tincture was given in doses of 10 minims and 2 drachms were taken in all.

Multiple Subcutaneous Fibromas

A patient was brought in and his abdomen examined. He is Matur Hedile, aged 29; a baker. Four years ago (1892) he had acute dysentery and was treated in the hospital. It was quite severe. His family and personal history are good. He denies any venereal disease. He came back in 1894 complaining again of diarrhoea and of pain in the back and stomach. The diarrhoea persisted for two months. He was discharged, cured. He returned to the dispensary in 1895 with buzzing in his ears. He said his health had been failing for six months. He came again in February 1896 complaining of pain in the abdomen after eating, headache and constipation. Last October he returned. His symptoms then were pain in the back, diarrhoea, weakness and loss of weight. He still had occasionally noticed mucus in the stools. He comes back today saying that his diarrhoea has stopped but that he has a great deal of abdominal pain.

He looks ill and pale but is well nourished. The abdomen is flat. It is symmetrical looking. There is a large number of pocks on the abdomen but very few on the face and arms. (In chicken pox this is the distribution. In small pox there are few pocks on the trunk; many on the face and arms.) Abdominal movements are normal on inspection. Multiple tumors are felt below the skin in the right hypochondrium. There is one between the umbilicus and the xiphoid cartilage and one or two in the left iliac region. Similar tumors are met with beneath the skin of the arms; two on the left, one on the right. Several are felt over the back on deep palpation. There are lines of atrophy of the skin (corium) over both iliac regions. They are large. Smaller ones are present over the shoulders. (These are liniae atrophicae.* They are seen in women after pregnancy).

* See page 26.

In the left iliac fossa there is a distinct resistance on palpation. This is the sigmoid flexure which is felt. There is no positive tumor. Upon rectal examination a mass is felt on the left side. It is slightly movable. (Look up atrophic lines of the skin. Look first under " skin " in the Index Catalogue of the Surgeon General's Library.)

Aneurism of the Aorta

Robert Clayton, p. 115. A man suffering from asthma is brought into the classroom. He is breathing with a great deal of effort. His breathing is forced and wheezy. The expirations are much prolonged.

His dyspnoea might be due to obstruction in the (1) larynx, (2) windpipe, (3) bronchi, or (4) smaller bronchioles. In the smaller bronchioles contraction of the smooth muscles of the wall or swelling of the mucosa might cause the obstruction.

(This case proved to be an aneurism of the arch of the aorta. Oliver's tracheal tugging sign was present. J. H. P.)

AMPHITHEATRE CLINIC

OCTOBER 21, 1896 — DR. OSLER

The little girl with malarial nephritis was shown (see p. 6). Sweat baths and diluents have caused the dropsy to disappear. She looks like a different girl. There is still a little albumin in the urine. She will probably never completely recover. She will return in one week.

Case VIII. Typhoid Fever With Multiple Intestinal Hemorrhages

George Carpenter (see pp. 30, 41, 46, 47) was admitted on October 11th. At eleven o'clock that night, the 19th of the disease, he had a hemorrhage which did not lower the temperature. It was slight. The bowel movement contained only 200 cc. of blood. He did well until the 16th. At 2 a. m. that night he had a second hemorrhage amounting to 500 cc. His temperature fell in one hour from 102° to 97.5°. Another hemorrhage

at a. m.; again 500 cc. He was very feeble; pulse 102; strychnia given hypodermically. On the 18th at midnight a hemorrhage of 250 cc. occurred. This did not influence his general condition. On the 19th at 11 p. m. one of 200 cc. This did not lower his temperature. Since then the only unfavorable symptom present is meteorism. He has been undisturbed. Lead and opium were administered. Today the meteorism is less; the temperature is 103°; the prognosis is favorable. Usually in hemorrhage the prognosis is favorable.

Case VII. Typhoid Fever With Bed Sores

The woman with bed sores was brought in. Bed sores are not always a reflection on doctor or nurse. Those on the heels of this patient are very deep and serious. The black gangrenous slough has not yet separated. *It will take as long to recover from the bed sores as from the original disease.* This should be a warning to move the feet frequently when the patient is so ill that he tends to lie long in one position.

Case IX. Typhoid Fever With Intestinal Perforation

Charles Hill was admitted August 15 on the 14th day of his illness. The temperature was 104° and he complained of great pain in the abdomen. He was operated upon by Dr. Finney. The appendix was swollen. A perforation was found in one of the typhoid patches. There were feces in the abdomen and general peritonitis had developed. He stood the operation well. The temperature fell to between 100° and 101°. There was a relapse from the 35th to 67th day. On the 34th day the temperature was normal. It rose abruptly on the 35th day from 99.5° to 104° in 24 hours. He had rose spots, an enlarged spleen, and all the characteristic signs of a relapse.

Finney has operated in 3 cases of perforation of the intestines occurring in typhoid fever. This was the only successful one. The earlier the perforation the less the danger, as later we have a mass of sloughs in the intestinal wall.

A relapse in typhoid fever is a repetition of the original

attack. As a rule a period of apyrexia separates the original fever from the relapse. In this case the relapse lasted from the 35th to the 67th day; that was a very long relapse. The mode of onset is variable in a relapse. In this man the temperature rose abruptly so it was first thought that another perforation had occurred. His temperature came down gradually.

Case X. Relapse in Typhoid Fever

Thomas Nahar, aged 37. He complained of weakness and loss of appetite. When admitted the spleen was palpable and rose spots were present. From the 10th to 18th of September his temperatue was low, 101°-102°. This is interesting, as he was seriously ill. On October 5 the temperature began to rise and on October 9 reached 103°. He was admitted late in the disease. His temperature fell gradually from the 45th to the 51st day. It then became subnormal, reaching 96° one day. The temperature in the relapse made a slow ascent from the 52nd to 56th day. This is the ordinary mode of onset. The relapse was a short one, lasting from the 52nd to the 67th day. He had rose spots. He is now in good condition, but is still very thin. The period of apyrexia is illustrated well in these two cases. It may last from several days to six weeks. One patient here had apyrexia 42 days; then a relapse of 42 days, followed by apyrexia lasting 16 days; then a relapse of 16 days duration.

Patients may have a relapse without apyrexia. After a week or ten days of low temperature (99°-100°-101°) the temperature goes up and a positive relapse occurs. Recovery in a relapse is the rule. It is sometimes difficult to say whether a patient has had a relapse or not. The treatment is the same as in the original attack, but often not for so long a period. The baths are continued; but should not be too cold. See the last *Johns Hopkins Hospital Reports* for the proportion of recovery in cases that relapse. Often the relapse may give us the diagnosis of the disease. Sometimes patients are admitted with a fever that has lasted for 5 or 6 days. There are no rose

spots and the spleen is not enlarged. Many of these are a simple continued fever of unknown origin. In some, however, a relapse occurs. Then we know the original attack was typhoid fever.

RECITATION

OCTOBER 17, 1896 — DR. OSLER

Liniae atrophicae may appear after scarlet fever. In the case of a rather stout girl there are actual splits of the corium over the knee, elbow and thigh. Look up in Crocker, or, better, in Unna *On the Skin,* in Orth's *Pathology.* This young girl complains of extreme sensitiveness in these marks, some of which are a centimeter in diameter.

At autopsy the other day there was found an example of obliterative appendicitis. Look in the Journal of the American Medical Association for Dr. Senn's article. He introduced the term *appendicitis obliterans.* It appeared last year or the year before. Hawkins, Fowler, Kelynack and Dever have written books on appendicitis. They are in the library of the Maryland Medical and Chirurgical Faculty, 984 North Eutaw Street. Obliteration of the lumen of the appendix is a process taking place in all of us. It is only dangerous when the obliteration takes place at the proximal end.

Subcutaneous fibrous nodules are met with often. See Futcher's article on rheumatic nodules in the Johns Hopkins Hospital Bulletin, Volume 6, pp. 133-142, 1895.

Types of Fever

In children, the normal diurnal range of temperature may exceed 1°. In some people the temperature beneath the tongue does not get above 97°. The rectal temperature is a little higher than the mouth, and the mouth higher than the axilla. The temperature of urine as passed is 99°. The skin at 103°-104° yields an intense pungent heat. Low temperatures are seen when serous membranes are affected with tuberculosis, as

in peritoneal tuberculosis. The lowest temperatures occur in hectic fever. For a large part of the day the temperature is subnormal in this type of fever. Alcoholic poisoning as seen in chronic drunkards is associated with a low temperature. An axillary temperature in winter of 95° was often observed at the Philadelphia General Hospital (Blockley) in alcoholics. A low temperature occurs in insanity. A large proportion of all fevers are of the remittent type. *Remittent fever* is the term applied to a certain type of malaria. Paroxysms may be broken, as in pyemia and tuberculosis. There may be a paroxysm without any chill. The height of the fever in a paroxysm is called the fastigium. The temperature in the malarial paroxysm usually reaches 105°. When the temperature is above 106°-107°, it is termed hyperpyrexia. Paradoxical temperatures are those above 112°. The highest temperature recorded here in this hospital was 115°. It occurred in a case of ulcerative endocarditis.

DISPENSARY CLINIC

October 27, 1896 — Dr. Osler

Subcutaneous fibromata run a very sluggish course. They are sometimes congenital. Virchow reports cases in three generations. Von Recklinghausen (1884) first studied them. He and some other pathologists state that they arise from the endoneurium. Virchow thinks they originate from the connective tissue of the fat layer; Weigert states that they arise from the subcutaneous connective tissue. They are painless. The painful ones are developed singly. The subcutaneous nodules in rheumatism may occur all over the body. Nodules may appear and disappear.

Aneurism of The Arch of The Aorta

Fred Buliver, aged 44 (see pp. 59, 98, 107, 114). He came complaining of cough. Notice his voice is very husky. This is of great importance. It is a peculiar wheezy sort of goose cough. He does not look very sick. The family history is

negative. He had smallpox at 20; rheumatism 5 years ago when he was in bed several weeks. Always ask the patient who says he has had rheumatism *if he was in bed.* Did he have fever? He denies lues. Use the term lues in speaking before patients—lues venerea. Trouble began in August one year ago with a cough. He began to be hoarse about May. When he first came to the Dispensary he was thought to have bronchitis. He entered the hospital July 18.

Inspection. The chest is well developed and nourished. Little dilated vessels are seen along the course of the diaphragm. These are very common, and of no special importance. Dr. Andrews of St. Bartholomew's Hospital first described them. They were formerly thought to have some relation with hepatic disorder. On the back there is acne vulgaris. In this disease the sebaceous glands become plugged; comedones form and later suppurate. Smallpox marks are seen over his face, especially on the nose. This is usually the location. A pulsation is seen over the right clavicle, also in the right infraclavicular region. The aortic beat is diffuse and slight in the suprasternal notch.—In thin and neurotic patients you can often feel the pulsation in the subclavian artery.—Pulsation is marked in the right brachial and right radial arteries. There is almost no pulsation in the left brachial or radial. The clavicles are not raised at all. The right temporal artery is very full and prominent. On the left side, the vessel can be felt but there is no pulsation. On the left side, there is no pulsation in the carotid. The veins are not enlarged in the left arm; color in both is good. Inspection of the back is negative; no areas of pulsation being seen.

On palpation the apex beat is not well felt. There is a slight diffuse impulse in the 5th interspace. The shock of the heart sounds is not felt at either apex or base. No pulsation is felt on deep pressure. Often one gets a throbbing when pressure is exerted with one hand behind and one in front of the chest while the patient holds his breath.

There is no increase in the area of cardiac dullness. On auscultation both sounds are heard at the apex. They are

clear. As we approach the sternum a short, sharp systolic murmur is heard increasing in intensity. It is of maximum intensity over the manubrium sterni, particularly over the right half of the manubrium. The aortic second sound is not accentuated. It is heard, but is feeble and distant. Over the pulsation in the right supraclavicular and subclavicular regions, the murmur is loud. It is very intense in the carotid artery and suprasternal notch, and faintly heard over the subclavian artery on the right side. The patient lies flat. Murmurs are not heard over the femoral arteries or the aorta.

The patient has sharp stabbing pains in the back; these are worse on coughing. He swallows his food all right. He is short of breath on exertion. He complains of (1) shortness of breath, (2) pain, (3) huskiness of voice—mark that (!), and (4) cough.

Summary of physical findings: On the right side the radial pulse is full; in the right subclavian and carotid arteries the pulse is very full. On the left side there is scarcely any pulsation in these arteries. He has a marked bruit at the base of the heart.

An aneurism in order to suppress the pulse in the left subclavian and left carotid would have to be in the arch of the aorta. There is evidence of increase of pressure in the pleural cavity, as the breath sounds on both sides are feeble. The respiratory murmur is not strong.

It is probably an aneurism or other tumor. The hoarseness is probably due to loss of power in one vocal cord, and is another of the pressure signs.

AMPHITHEATRE CLINIC

October 28, 1896 — Dr. Osler

The patient with bed sores was shown. Now the sloughs on the heels are off and the ulcerations are granulating nicely. The bone was not exposed. It will be a matter of some weeks before he is fully well. The back is almost healed.

Both the relapse cases are well. A paper on "Relapses in Typhoid Fever" was read by Mr. C. R. Bardeen of the senior class. He stated that Murchison showed that lesions in the relapse are higher up in the ileum than in the original attack. They may even be in the jejunum. The spleen is apt to be enlarged throughout the period of apyrexia. "This is very important, and we have noted how long the large spleens persist in the convalescent stage," Osler stated. Sanarelli says a relapse is due to micro-organisms still remaining within the body. Rainer showed the presence of bacilli in the stools weeks after apyrexia had set in. They have been found in bones years after the attack.

Case VIII. Typhoid Fever. Intestinal Hemorrhage

George Carpenter (see pp. 23, 41, 46, 47). I spoke of him, I think, at the first lecture. He is a young man who had a hemorrhage on the day of admission. He has had 7 in all, the last on Sunday. Admitted on October 11. He had a hemorrhage on the 12th; moderate in amount. It did not reduce his temperature. The second was on the same day in the evening; the third on the 16th, amounting to 55 cc.; the fourth on the evening of the 16th of about the same quantity; the fifth at midnight on the 17th; the sixth at midnight on the 19th; the seventh at 2 p.m. on the 25th. It was severe, amounting to 500 cc., and blanched him very much indeed. An infusion of salt solution was given, nearly a liter. Since Sunday, the 25th, he has been better. The temperature is still high, 104°; pulse high. He is rational. There is no abdominal distention and he still has a good fighting chance. He is getting whiskey, strychnine, lead and opium pills. When his temperature gets above 103° he is given cold sponge baths.

Case I. Pneumonia

Of the four acute fevers in this region we see chiefly typhoid fever from September to January; also malaria at this season. The pneumonia cases occur chiefly from January to April.

Dysentery varies in different years. Goldie Flarety, age 39. This is the first pneumonia patient admitted this fall. He has a triple infection. In addition to tuberculosis and syphilis, he is just convalescent from an attack of acute pneumonia. He had on admission sharp pain in the left side, a chill, and a temperature of 102°. A uniform consolidation of the left lower lobe was present. There was dullness, increased fremitus and all the other signs. Flatness was present over the left lower back from the 7th rib downward. He had rapid respiration. On the 3rd day he looked very ill. On the 7th day temperature dropped; falling from 104° at 6 p. m. to 98.2° at 4 p. m. on the next day. It was a well marked crisis, but the temperature remained normal for only a few hours. Then he had slight fever for four days, 99° to 101°. Now his lungs are clear and he is doing well. An interesting condition is present. It is a blotchy erythema over the skin. There are no positive wheals.

Malaria

You remember the case with remittent fever (page 20). It was treated for typhoid fever. We had him in the house 5 or 6 days before the parasites were discovered. There were very few parasites in the circulating blood. It seems that examinations can be made repeatedly without finding the aestivo-autumnal parasite in the blood. A similar case in a patient, aged 18, was admitted Sunday, the 27th. He had worked in the city for 8 months. On September 21 the illness began with pain in the head, weakness, loss of appetite, bleeding at the nose and vomiting. There was no distinct chill. He went to bed on Friday the 25th. On admission the examination was negative except the spleen could be felt. No rose spots; pulse regular; fever not high, 102°. Blood examinations were repeatedly negative. On the 8th day the temperature became normal. It was thought to be a very mild case of typhoid fever. On the 16th day of October the temperature began to rise. Osler thought it was a relapse as in cases with mild fever of 7 or 8 days' duration a relapse often occurs. His fever was

irregular. He developed herpes and became slightly jaundiced. On October 23d organisms were found in the blood.

In Philadelphia Dickinson of Edinburgh, when a guest at Osler's clinic, referred to Murchison's dictum that " a continued fever that lasts 10 days without local symptoms is typhoid fever." The Philadelphia case in question also turned out to be malaria, although it was shown to the class as one of very mild typhoid fever.

Woodward's work on the intestinal fluxes in the Civil War is a perfect mine of information. No article in any language is the equal to this on the subject of dysentery. Here in Baltimore amoebic dysentery is very common. See Councilman's very exhaustive article in Volume II, *Johns Hopkins Hospital Reports.*

RECITATION

OCTOBER 31, 1896 — DR. OSLER

Obliterative appendicitis is a term applied by Senn. It is a very common degenerative change, being present in 25% of 300 autopsies.

In examining patients, *method* is all essential and also in keeping records. In inquiring for tuberculosis it is as important to ask whether the patient's family has moved into a house lately, as to inquire in regard to the antecedents. Gaertner's monograph on *Heredity in Tuberculosis* is excellent.

When a man comes with locomotor ataxia or dementia paralytica you can ask point blank, " When did you have the primary sore? " In a child three months old with snuffles and a rash on its buttocks, don't ask a question of the mother. It means syphilis in a three month old child every time. A woman who gives birth to a syphilitic child is herself immune. This is known as Colles' law.* Syphilis is the only disease you have to know. In order to understand the complications of syphilis you

* " The mother herself may be, and often is, apparently quite healthy, but the Wassermann reaction is present, and it is through her and not directly from the father that the disease is transmitted." Osler, " Principles and Practice of Medicine," Eighth edition 1912, page 265.

have to know surgery, dermatology, ophthalmology, otology, neurology, and internal medicine. In knowing syphilis well you bring in all the rest incidentally.

Aortic insufficiency in men is due to (1) hard work and (2) alcohol. Mitral insufficiency in women is due to rheumatism and is more common in young girls than in men, and so is chorea.

Rheumatism has distinct sequelae, such as heart disease.

Osler cited a case of bony nodules (multiple) on the skin, ribs, and elbow of a young girl. There was no history of lues. She had had a mild fever of ten days duration a month or so before. They were bony nodes due to typhoid fever, and the bacilli were demonstrated in them.

Marchiafava and Celli's work on malaria was translated by the New Syndenham Society. *Die Malaria Parasiten* by Mannaberg (1893) is very good. Marchiafava and Bignami's monograph published in 1892 is also important.

DISPENSARY CLINIC

November 5, 1896 — Dr. Osler

Look up the evolution of the signs of pneumothorax. The succession splash was known to Hippocrates. It is very interesting to trace the history of our knowledge of the signs of pneumothorax.

Habit Spam or Tic

Lelia Smith, age 18. She first came five weeks ago with chlorosis. Her hemoglobin has gone up to above normal. It was 60% when she was first seen. She has taken iron pills steadily. Examination: She still looks pale. She has nervous twitching. Every few minutes she has a little movement of her trunk. The movement has never been in her face. There are little movements of the head; some more marked than others. Occasionally one notes a little respiratory sniff. She has clonic spasms of certain trunk muscles, neck muscles, and at times a

quick clonic movement of the eyelids and a sudden clonic sniffing movement. There are no movements of the hands or feet. She came on October 9 complaining of her nervousness and was very pale. The family history was negative except that a cousin had the same trouble. This condition has persisted from her ninth year on. She is never without the twitchings but they are worse at times than at others. She does not think it has involved the body for more than a year. "Do you notice if your legs twitch at all?" "No." On examination her shoulders are shown not to move, either. She has never said any words when these motions seize her. Question repeated. "Does not your mother ever complain that you cry out or say words?" Emphatic denial. Does not snort in her sleep. Her eyes do not trouble her. Two years ago she wore glasses for a time. Throat examination was made. There is a little swelling behind the tonsils and some mucus in that region. She was told to go to the throat clinic.

This girl is the subject of slight clonic convulsive movements. They recur every minute or two. There is large group characterized by clonic spasms. *Clonic* are rapid quick movements which follow each other and are not constant, while *tonic spasms* are persistent contractions. In an epileptic fit you have as the first stage, tonic spasms. The patient's arms and legs are involved in tonic spasms. Later the clonic spasms come on.

Chorea minor or St. Vitus' dance is very common in children. Clonic spasms occur and are chiefly confined to the extremities. It looks like an exaggerated attack of the fidgets. The movements are irregular and involuntary. Chorea minor occurs chiefly in children. It affects the extremities and lasts from 6 weeks to 3 months. In exaggerated forms the child may throw itself about to an alarming extent, and the disease often may be associated with mania. In the Middle Ages, people under strong religious excitement would dance until they dropped. Hence it was called "the dancing mania." Burton's *Anatomy of Melancholy* gives a very interesting account of it. This was written about 1620. He gives Paracelsus' original account. The name chorea was given by Paracelsus. Syden-

ham read Burton undoubtedly, and gave the name to this disease of children which has nothing to do with the dancing mania. Chorea minor = Sydenham's disease. Chorea major occurs under excitement of religious gatherings, etc. It appeared early in this century in Kentucky and Virginia. It was described by Robertson.

Habit Spasm

The irregular twitching of one muscle or some one movement is termed mimic spasm. It is sometimes quite noticeable. It appears in intellectual people. It was called habit chorea by Mitchell. Never use the term. Call it habit spasm or tic (facial tic). When limited to one group of muscles such as produce a movement of the eyelids or eyebrows or a sniff, for example, call it simple tic. This is usually confined to the face. When groups of muscle are involved, it is termed a generalized tic.

Impulsive Tic

Gilles de la Tourette described additional phenomena. Most of them are really mental in origin. This condition is known as tic convulsif or tic Tourette. A case was reported by Osler. The patient had the habit of putting his middle finger in his mouth every few minutes and biting it while at the same time he touched his nose with his forefinger. The touching mania is an irresistible desire to touch things. Those afflicted have a fixed idea that they must touch certain objects. Dr. Samuel Johnson felt compelled when walking on the street to touch every post that he passed. A fixed idea of this sort is common in children. Few escape being thus affected in some period of their life.

A more serious form is characterized by explosive utterances such as a barking or, more commonly by making incoherent sounds. Often the patients will imitate certain sounds, or will mock every word one says or certain words. Charcot called this echolalic, that is echoing speech. Some will use frightful language—oaths and obscene words. This is known as copro-

lalia or fecal speech. They use the words when the spasm seizes them. Some have to count so many times before they do certain things such as going to bed. This counting mania is called arithmomania. Most of these cases are incurable.

The outlook for the girl is dubious as regards complete recovery.

The French writers have given the most attention to this disease. It is not yet well known in America. See Osler's monograph on chorea.

Syphilitic Periostitis

Ed. O., age 41. Complains of swelling and pain in the right shin bone. Pain is severe at night. The bone is tender, and there is a marked swelling on the tibia. The ankle is also swollen and is oedematous. The sharp edge of the tibia is completely obscured. It is firm and there is a node present. This is a case of subacute periostitis.

This man had his original attack of syphilis 6 years ago. He has had no skin eruptions for some time past. This node on his skin is unquestionably due to lues venerea. He has enjoyed good health and has an excellent appetite. From bed time at 8 p. m. to 11 p. m. he has severe pain; after that it eases up and he is able to sleep.

Treatment—Give inunctions of mercury for a week and after that 30 drops of the saturated solution of potassium iodide a day. Keep on with the potassium iodide for a long time.

RECITATION

NOVEMBER 7, 1896 — DR. OSLER

Purpura Simplex

A patient is brought in. N. Grant, age 19. There are raised areas on the flexor surface of the arm chiefly, but also on the neck. There are a few on the leg and abdomen. They are macules, not papules. They might be extravasations of blood or erythema. The latter would blanch on pressure. These do

not. They come out in crops. Those on the neck look different and are older. These are ecchymoses or purpura. The smallest ones are called petechiae. Very large extravasations are called sedulations. We call these present in this case purpura.

The first attack came on the 25th of March. He has had several milder ones since. "Is there no pain in the belly?" "No." "No vomiting? No blood in your urine?" "No." Purpura is a symptom, not a disease. Cutaneous hemorrhage with no swelling of the joints, no fever and no other symptoms we speak of as *purpura simplex*. It occurs most frequently in young people and is apt to recur. There is often slight anemia. All grades occur ranging from cases like this with a few spots and little general disturbance to the other extreme which is known as *purpura fulminans*, the malignant purpura. In this severe form the whole body may be covered with these hemorrhages, and death may occur in from 24 to 48 hours. The pathology is unknown. The old view has been that the changes were in the capillaries but the recent researches of Wright of Netley show the change is in the blood. The coagulation time may be delayed to 10 minutes or even much longer.*

In hemophilia (bleeders) the coagulation time may be delayed as long as 50 minutes and in one case 54 minutes.

Look up the use of iodides in syphilis. Look first in the Index Catalogue of the Surgeon General's Library. The United States Dispensatory and the National Dispensatory give points as to the history.

Abraham Colles was born in 1773. He took his degree in 1797 at Dublin University; and was made lecturer of anatomy and surgery in 1804. He died in 1843. The Colles of the Colles fracture is the same man. Colles' works edited by Robert McDonald were published by the New Sydenham Society. His law is that the mother of a syphilitic child although she may not have contracted the disease, may suckle the infected child with impunity. Read Fournier's books on hereditary syphilis. They are written in French.

* It was shown some years later that in purpura the coagulation time was normal but the bleeding time in thrombopenic purpura is increased. JHP.

Pain

Failure to recognize the existence of pain may be due to dullness or the misstatements of patients. *Shock* prevents pain. Sometimes pains are simulated. In Germany and among soldiers in all nations there is much malingering. There is little in this country. Read the subject of malingering in books on medical jurisprudence. Severe pains in the abdomen and recurring attacks of colic without definite cause lead one to suspect the patient has the morphine habit. The pain is caused by the withdrawal of morphine. In pleurisy, pneumonia, and appendicitis the pain may begin so suddenly that the patient can fix the time of onset almost to the minute.

The causes of pain in the lower axillary region of the left side were discussed. A stitch in the anterior part of this region is due commonly to stomach trouble. If it comes on acutely and is very severe we suspect pleurisy. In herpes the pain may be very persistent. Patients have committed suicide on account of the pain of intercostal neuralgia. The pain of pleurisy or pneumonia at onset is very acute. No explanation offers itself for this sudden pain.

DISPENSARY CLINIC

NOVEMBER 12, 1896 — DR. OSLER

Cachectic Purpura

Look up convulsions in syphilis in Fournier's articles, also H. C. Wood's in Pepper's *System of Medicine.*

Woman aged 59 years. Now and then for a year she has had purpura with large areas of ecchymoses in the skin. The outbreak at present is on the central part of the thigh, involving the anterior surface. It is 5 x 6 cm. in extent. It looks fresh. It is tender; not raised. It looks fresh because the color has not diffused yet. She is a pale, debilitated woman.

Do not give potassium iodide in hemorrhages occurring in syphilitic patients because it causes hemorrhages. First give

iron and arsenic as a general tonic and build the patient up when old and debilitated like this one. Often these hemorrhages appear without apparent cause.

AMPHITHEATRE CLINIC

NOVEMBER 11, 1896 — DR. THAYER

Case XI. Tender Toes in Typhoid Fever

Martin Broughton (see p. 46). He is a patient with tender toes. Usually there are no constitutional symptoms. Here the rise of temperature was rather remarkable. His calves are swollen and yesterday there was slight oedema around both ankles. This points to phlebitis as well as neuritis. This man had a very sudden rise of temperature.

Case XII. Typhoid Fever Relapse

Woman. She is having a relapse. The temperature rose slowly, in this case taking four days to reach 103°, which it is now. There are no rose spots yet but manifestly she is in the course of the relapse. The spleen is not palpable. It never has been, as the abdomen is rather tense.

Case XIII. Typhoid Fever Relapse

This man's temperature reached normal on the 22nd day of the disease. On the 24th the morning temperature was 100°, the next night 104°. Since then this high temperature has been maintained reaching 105° one. A fresh crop of rose spots has appeared.

Post-Diphtheritic Paralysis

Mother, and child aged 2 years, admitted October 15. The child's illness began 2 days before entrance. He had a sore throat and swelling at the angles of the jaw. He had had several convulsions. He was given antitoxin twice before entrance. When admitted, the tonsils were enlarged. There was a grayish membrane on the pharynx and a foul discharge

from the nostrils. There was quite marked dyspnoea. He was given 1500 units of antitoxin. His throat cleared up quickly. It appeared clean on the 19th. On the 21st he became cross; the temperature rose and an urticaria with wheals developed. The urine showed albumin and casts. The urticaria has disappeared and he is now convalescent. A few days ago his voice became hoarse and water on swallowing came through the nostrils. His voice is very wheezy. "Say P." It sounds like "M." He chokes on swallowing. His walk is quite ataxic and unsteady. His velum hangs flabby. He has then a paralysis of the soft palate. The knee jerks have disappeared.

Mrs. Freeman, aged 24, the mother of this child, was given 500 units of antitoxin on the day of admission. She had a pseudomembrance which after entrance extended to the uvula. In three days the temperature became normal. She had difficulty in swallowing, and fluid came through the nose, but this paralysis has disappeared. The velum on the left side hangs lower than on the right side. She had a paralysis then of the velum and uvula of the left side only.

This complication in diphtheria is very important and very common. Its frequency is from 10 to 20% of all the cases. It usually occurs in the first three weeks of the disease. The paralysis most commonly involves the soft palate; then various pharyngeal muscles; then ocular paralysis (paralysis of accommodation); then paralysis of the lower extremities. There is loss of power with marked ataxic symptoms. Sometimes the neck is affected and the child's head hangs helplessly forward. There may be a paralytic euphoria, that is an absence of pain or bodily distress in spite of the paralysis. Disturbances of sensation are very rare. A loss of the knee jerk can be made out often when no other symptom appears.

The paralysis is due to a neuritis and can be produced experimentally by the toxic substances themselves. Chamfeld described two cases of multiple sclerosis following diphtheria. Multiple sclerosis frequently can be traced to some infectious disease. Hemiplegia may occur. It is usually due to hemorrhage. See J. J. Thomas' article in the April number of the

American Journal of the Medical Sciences. The sudden heart failure may be due to muscular changes in the heart as well as to nerve changes. Postdiphtheritic paralysis is important from a diagnostic standpoint. It may follow very mild symptoms that have been overlooked. So the throats of all suspicious persons in an infected family should be examined bacteriologically, as they might spread the disease. Duckworth places postdiphtheritic paralysis at from 10 to 20%; Hoppe-Seyler of Kiel 27%; Ochanis of Norway 12½%. In 3048 cases there were 11% which developed postdiphtheritic paralysis. There must be many that the physicians did not see. So 11% must be regarded as low. Antitoxin treatment saves 10 to 20 lives in a hundred cases. Babinski says more cases of postdiphtheritic paralysis have occurred since the introduction of antitoxin. Von Noorden reported 21 in a series of 87 cases of diphtheria. The American Pediatric Association (1895) collected 328 cases of postdiptheritic paralysis out of 3384 carefully examined (5000 cases in all). This is 9%. The apparent increase may be due to the fact that the patients who would have died have been saved but the cases were so severe that paralysis followed. The sudden deaths from heart failure increased under antitoxin. The reason is the same as that just stated.

Treatment: The patient should be kept very quiet. Even with antitoxin, we should not let up our vigilance, especially so since the statistics show the danger. The prognosis is good in postdiphtheritic paralysis except when it affects the muscles of (1) deglutition with the resulting danger from the inspiration of food particles and (2) the respiratory muscles. This is of extremely rare occurrence.

The patient should be given massage and passive motion. Electricity may be used, although it rarely is of benefit.

Case VIII. Hemorrhage in Typhoid Fever

George Carpenter (pp. 23, 30, 46, 47). This is the case with multiple hemorrhages. The bronchopneumonia he had last week

has cleared up. A couple of days ago his temperature went up to 106° with evidence of pneumonia and pleurisy of the right side. But he is doing well.

Syphilis. Mucous Patches and Gumma

Woman, age 30. She complains of sore throat. Two years ago she had a small sore over the pubis; probably a primary infection. She has pain on swallowing. Her hair has been falling out. The patient is a healthy-looking girl. There is a nasty, grayish patch which looks eroded on the back of the pharynx. In the center of the forehead there is a roundish prominence. The skin over it is freely movable. It is a little glossy. There is no oedema around the swelling. It feels semi-fluctuant in the center and hard at the edges. The cervical glands are much enlarged; one behind the left ear is the size of a large walnut. There is nothing on the clavicles. The other bones are all right. Her shins are quite clear. There are no cutaneous lesions. The liver is not enlarged. Nodes of this type are treated in the medical clinic.

The distinct nodules on the surface of the liver (gummata) should have been palpable in the autopsy case we have just seen.

Treatment: Potassium iodide 15 grains a day for the present and later we will increase the dose.

DISPENSARY CLINIC

NOVEMBER 17, 1896 — DR. OSLER

There is a note in the *British Medical Journal* this week on potassium iodide. Dr. Wallace (1832) introduced potassium iodide into the treatment of syphilis. In New York in cerebral syphilis and in the associated diseases tabes and progressive paralysis, enormous doses of 900 or 1000 grains per day are given.

Erythema Nodosum

Mrs. Miller, age 45 (see p. 76). She came to the hospital in March complaining of pain in her head. At that time she had neuralgia. There is nothing of special significance in her family history. She has had pneumonia, pleurisy and seven children with no miscarriages. Fontal headache for a year. She has not had sore throats. She has never been laid up in bed with swollen joints. This month an eruption came in crops which have appeared and disappeared. The trouble has been only in the legs. They were not sore, and didn't itch but burned " right smart."

Objective examination. They look something like bruises. On the left leg there are eight; mostly on the outer side. The color is diffuse, more marked in the center. It is brownish red. The margin is diffuse. They are nodular indurations; painful on pressure. Two or three show light abrasions on the surface. On the right leg there are three or four. A large fresh one, a little above the external malleolus is 3.5 x 2 cm., in size, is brighter red in color than the others and shows on the top the beginning of vesication. Scattered over both feet are several smaller more papular ones.

This is a very interesting condition. It is unusual to occur so late in life. It is rarely seen above the 40th year, and is most common in girls between the ages of 18 and 25. Nodular erythema is a good name. It is not uncommonly seen in medical practice and is allied to the whole group of erythemata. The different types are very confusing. The common situation is the leg and as a rule only the legs are attacked. Oval swellings form over the tibia varying in size from a pigeon's to a hen's egg. The long axis is in the direction of the tibia. They soften later and may fluctuate but never suppurate. In this case the eruption came on without swelling of the joints and no fever. Usually both occur. A rheumatic taint is frequently present. Erythema nodosum is regarded by some as a manifestation of rheumatism.

Treatment. Iron, best employed in the form of the per-

chloride, is used in the severer cases. We will take the blood coagulation time. It has been shown to be slowed in purpura (see footnote p. 37). Recurrence is less frequent in erythema nodosum than in other varieties of erythema. Salicylates do good. If the blood coagulation is retarded, use calcium chloride. Recurrence is the rule. Crocker does not lay enough stress upon its frequency.

It is a question whether erythema is a specific disease. It is not at all uncommon to see it as a secondary affection in many diseases. You remember the case of typhoid fever shown at the first Wednesday clinic in October and the woman with subcutaneous hemorrhagic blotches shown last week. She may very likely come back with erythema multiforme or erythema nodosum.

The normal blood coagulation time is 3 to 4 minutes. In these capillary tubes it ought to be coagulated in 3½ minutes, if normal. This patient's coagulation time is 3 minutes.

We saw herpes in a case of malaria. It is also seen with great frequency in pneumonia. It is commonly associated with these two diseases.

Chancre, Rash and Periostitis in Syphilis

Male, age 52 (see pp. 53, 58, 68). He appears young for his age. Healthy looking man. German. Fought in the wars of '66 and '72. He has scars of wounds in neck and knee. His respirations are peculiar being short and grunting. His face is suffused. Pulse 80. Respirations 44; very short breaths. Temperature 98°. Evidently the rapid breathing is just emotional. His eyes are flushed. Forehead and neck are a little red. The skin over the abdomen is covered with a rash, bluish red in color. It is patchy, not diffuse. The patches fuse in places forming quite large areas. It is a dusky mottled rash, giving the appearance of being deeply seated. The eruption is dusky. It is present on the back, abdomen and arms. It looks most like the rash of measles; not much marked on the legs.

His primary infection occurred on July 4. The chance ap-

peared two weeks afterwards. The chancre on the corona is indurated, V-shaped, and well marked. His shins are clear. There is a remarkable stiffness in his movements. The right sternoclavicular articulation is affected and the sternal end of the clavicle is enlarged. These swellings are due to periostitis. It is unusual to have marked periostitis so early in the disease. Old bubo scars are present. Twenty years ago he had a bubo.

AMPHITHEATRE CLINIC

NOVEMBER 18, 1896 — DR. OSLER

A relapse in typhoid fever may occur after fever has been absent for 6 weeks or on the other hand may start in without any period of apyrexia. The fastigium may be reached in 24 hours or in four or five days.

Case XIV. Typhoid Fever Relapse. Tender Toes and Fingers

This man has abundant rose spots in his relapse; none in the original attack. This is interesting. His temperature chart shows the fever in the relapse is higher than in the original attack. In the original attack the maximum was 102.5°; in the relapse a maximum of 105° has been reached several times. He is now in the 15th day of his relapse and the temperature is down to 100°. He has tender toes. The ball of the toes is red and swollen. He has also tenderness in the hands and fingers, which is quite unusual. No similar case ever seen by Dr. Osler. His tongue is clean. That is a good sign. Probably the temperature will be normal in a few days.

Case XV. Relapse in Typhoid Fever After 21 Days of Apyrexia

This is an interesting case. The temperature became normal on the 28th day of illness. This was followed by 21 days of apyrexia. Then the temperature on Nov. 4 began to rise in a steplike way, as in the original attack. It took 4 days to reach the fastigium. The fever of the relapse lasted 18 days; going

down gradually. There was only one rose spot. No diarrhea. The spleen was palpable.

Case XI. Typhoid Fever. Tender Toes. Thrombosis

You remember Martin Broughton who was shown last week (see p. 39). He had tender legs. It is a remarkable case. We thought he probably had phlebitis. There was a post-typhoid elevation of temperature, possibly associated with a thrombus in one of the veins of the calf.

Case VIII. Death from Pleurisy in Typhoid Fever

George Carpenter (see pp. 23, 30, 41, 47) of whom I spoke several times died last week of pleurisy. He had 7 severe hemorrhages. Two nearly proved fatal. The last hemorrhage was on the 25th of October. After despairing of him for two days his temperature came down below 102°. From the 8th to 10th of November the temperature was between 101° and 102°. Then on November 11th, the 32nd day of his illness, when everything seemed favorable, he complained of a sharp pain over the heart. This was due to an intense pleurisy. His temperature rose to 106°. The pulse was almost uncountable. There was a rapidly developing leucocytosis. He died on November 12th.

Intestinal ulcers from this case were shown. They are smooth in their bases and healing most beautifully. There are very few ulcers in the ileum. The local disease then was healing most satisfactorily when the fatal pleurisy developed.

Pleurisy in Typhoid Fever

First we have the pleurisy of onset. It may be slight. This is of no special moment. The patient complains of some pain in the side and a slight friction rub is perceived. On the other hand it may be very severe. This is pleurotyphoid. It may not enter your mind that the case is one of typhoid fever. The patient is seized with sudden intense pain in the side. This may dominate the disease for an entire week. There is pain, a friction rub, and soon an effusion may form. Attention to the

abdomen then often reveals to the physician's surprise an enlarged spleen and rose spots.

A girl was admitted September 21, 1896. Nine days before admission she had a shaking chill, which was quite severe, followed by fever and sweating. Since then she has had a cough. Yesterday she was seizezd with a severe pain in the side, which become worse on deep inspiration. On admission, she complained of pain when she moved. On the 22nd day of the disease the temperature was 104° The sputum showed no tubercle bacilli. Expectoration was slight; not blood stained. On the 25th day she looked very ill; more so than in an ordinary case of pleurisy. On the 26th day for the first time definite rose spots were seen. Baths were ordered and she was bathed in spite of the pleurisy. The pleurisy did not develop further. On October 13 dullness at the left base had almost disappeared. In the 56 baths given over a period of 10 days the pleurisy progressively improved and the cough was not aggravated. This is interesting to note.

Four cases have been admitted with acute pleurisy at onset. Much more common is pleurisy, dry or with effusion, in the course of the disease. In Carpenter's case the onset occurred on the 32nd day. And in 48 hours a full litre of turbid fluid had been thrown out and a cremy exudate covered both layers of the pleura. It was a streptococcus, not a typhoid, pleurisy. There may be a pleurisy without pain in the side or anything to call attention to the complication. The effusion may be entirely latent. Such a case was cited. Two days after admission a friction rub was noted. On the 4th day evidence of an effusion was detected, but in this case there were no symptoms of pleurisy. Then there is the pleurisy of convalescence. It may be a simple effusion or an empyema. The latter is very rare. In 56 autopsies performed by Dr. Osler on typhoid cases in the Montreal General Hospital there were only 2 cases of empyema.

Other Types of Onset in Typhoid Fever

Typhoid fever may begin with a pneumonia. These cases are very puzzling. The diagnosis may not be made until the 8th or 9th day. Then when the crisis does not occur, for the first time suspicion that it may be typhoid fever is aroused.

Typhoid fever may begin with a nephritis or a meningitis. It is not a true meningitis but simply a cerebrospinal form of the disease.

Case XVI. Collapse in Typhoid Fever

In the case of Anne Andor (see pp. 61, 72) deafness developed. When this occurs note very carefully if there is any discharge from the ears. She was so weak and neurotic that tubs were not used. On November 9 her temperature rose to 105°. Her pulse suddenly went up to 160 and the temperature fell below normal. All the symptoms of heart failure were present. Her temperature was 103° at 12 midnight November 8. At 3 a.m. 105°! at 10 a.m. 98°. It remained about 98° until 6 p.m. At 8 p.m. 99.5°. At 12 midnight 102°. This was a very curious attack of delirium cordis. Since then the temperature has been gradually falling. She is now doing very well, but is extremely weak. As she recovers from her typhoid fever, she will probably have her chlorosis cured. This is the only case we have had of typhoid fever attacking a patient who had severe chlorosis. Her hemoglobin was down to 49% on admission.

Since the session opened only two deaths have occurred among typhoid fever patients: (1) the patient who died from hemorrhage; (2) Carpenter—with pleurisy as a complication. No deaths from the common causes (1) adynamia and (2) perforation.

DISPENSARY CLINIC

NOVEMBER 19, 1896 — DR. OSLER

A student read a note on the succussion spash in pneumothorax. Itard (1803) gave the name pneumothorax. Hippocrates, however, was acquainted with the succussion splash.

Laennec (1816) noticed motion of fluid in the chest and moveable dulness. Trousseau (1859) described accurately the coin test (*bruit d'airain*).

The syphilitic patient shown last time had old bubo scars. This pointed to a soft chancre. Look up reinfection in syphilis in the *Index Catalogue*, the *British Medical Journal* and *The Lancet* for the last two years. See also Hutchinson's *Archives of Surgery*. Jonathan Hutchinson has had the largest experience in syphilis of any living man. He is a most accurate observer of facts. One can not depend so much on his conclusions.

Rheumatoid Arthritis

John O'Halleran, 60 years (see p. 60). He has been a painter for 45 years. He comes complaining of his joints. He is a healthy-looking man. He never had painter's colic. In 1888 he had lead paralysis, with severe wrist drop. It was 11 months before he could feed himself. This trouble in the joints with red spots came on before he was well. It has been progressing. He never had acute arthritis of the big toe. "What were your drinking habits?" When a young man, he drank only beer. He did not lose time by drink. He did not use tobacco. He is a heavy meat eater. His hands were first affected, then the shoulders. The feet have been swollen for five or six weeks; never swollen before.

Objective description: Healthy looking. His complexion is good. His eyes are clear. No arcus. (Painters are subject to gout, so examine his ears.) No tophi. His hand are much deformed. There is an ulna deflection. The knuckles are swollen. There is wasting between the metacarpal bones. The small joints of the fingers are not much swollen. There are no obvious chalk stones. The left hand is not so much swollen as the right. His finger nails are not ribbed. Over the little finger of the left hand a hard movable nodule is felt. It feels like a hard fibroma. There is a large one on the inner surface of the middle phalanx of the middle finger of the right hand. Others are seen. Excepting one on the little finger they are not red

and all feel fibrous. He can make a fist with both hands. The deformity of the knuckles is very great. The heads of the bones are much enlarged, and there is a great ligamentous increase. A uniform swelling of the ankle and over the dorsum of the foot is present. There is some oedema, particularly over the external malleolus. Venules are visible. There is a large callosity over the back of the heel. This was the right foot that was examined. Not much trouble in the knee or elbow. On flexing and moving the finger joints they all grate; also there is a slight grating in the knees. The trouble in the fingers first came on with the paralysis. Soreness and redness come and go. He says every joint has been affected except in the head.

Here we have to determine whether we are dealing with chronic rheumatism, arthritis deformans, or gout. He has been a painter and a good deal of a drinker. These both favor the diagnosis of gout; a disease seen particularly in England and Scotland. He has no symptoms of acute gout. There are no tophi in his ears. In gouty arthritis usually the chalk stones are pretty positive. Here the ulna deflection which produces the "*fin-like*" *shape is almost characteristic of arthritis deformans*. Chronic rheumatism rarely develops this deformity. He has a good pulse, easily compressed; very little sclerosis. Good arteries for 60 years. The heart sounds are clear; the second aortic is a little loud and ringing.

Treatment: Rest with feet elevated for two weeks. Soak a towel in cold water and wrap it around the feet with a coarse piece of flannel. Change the wet towel every two hours. Also at bed time letting it remain all night. Have the joints rubbed half an hour every night with sweet oil. Rub up and not too hard, so as not to cause pain. Give potassium iodide, 10 grains twice a day. This is good while the joints are still painful. The rest and persistent packing and the massage will do more good than the whole pharmocopeia.

Painters as a rule have arteriosclerosis. This man has remarkably good arteries. The enlarged knuckles are sometimes called Haygarth's nodosities.

Diabetes Mellitus

Frank Schlenke, age 54, Bohemian. He complains of pain in the back and thirst. The family history is good. He has been a heavy drinker. He has had pain the back for two years with thirst. He passes a large quantity of clear urine. There is progressive loss of weight and strength. He is always eating, always drinking. He is drinking day and night. When we get this story, we at once suspect diabetes. The urine has a specific gravity of 1030. It contains a large amount of sugar. In diabetes the plasma is always milky as it always contains chyme. This is due to the fact that the intestines are always full and are always digesting food. Sometimes the milky appearance is seen in the blood clot and in the heart's blood when diabetic patients go off rapidly with coma. Trousseau tells of a diabetic patient who was paid to keep away from a restaurant where they served meals *table d'hote*.

DISPENSARY CLINIC

NOVEMBER 21, 1896 — DR. OSLER

Exophthalmic Goitre

A paper on *Exophthalmic Goitre in Children* was read by Miss Emma E. Walker. The exophthalmos is sometimes lacking. In this disease the forehead will not wrinkle. The tremors are rapid (8 to the second). The palpitation in a case observed here was noted after the eye symptoms developed. Dr. Abraham Jacobi reported 12 cases of exophthalmic goitre in children (1879). His youngest case was aged 2½ years. All the cases reported in children have been in girls. The ages ranged from 8 to 13. The average was 9 years. Treatment: belladonna and, in addition, strophanthus is often given.

There are definite changes in the thyroid. The colloid is converted into a mucoid substance. Thyroid extract, as a rule, aggravates the condition. Factitious urticaria is seen in passing the hand over the skin. The prognosis in exophthalmic

goitre is not very satisfactory. It is said to be more so in children. Cures are few and far between, unlike its antithesis myxodema. The system is thought by some to be charged with the thyroid products; so-called hyperthyroidism. Two sisters entered here, one with myxodema—she lost 17 lbs. in — days under thyroid extract,—the other with exophthalmic goitre.

Henoch's Purpura

Joseph Soss. He came complaining of " pain in the stomach and spots on the leg." —— months ago he began to have pains in the right side of the abdomen. Pains were quite severe for — months. Later, pain became centralized. He now has pain all the time; not cramp but just soreness. He never vomited with the pain. He does not appear to have had paroxysmal attacks. The pain is so bad at night that it prevents sleep. Never had bleeding from the gums. He is a pale delicate-looking fellow. The gums are not spongy. No marked dermatographia. This is the name given to an extreme hyperaemic condition of the skin. Sometimes writing comes out on the skin in raised wheals. It is an indication that the nervous system is a little out of gear. The red lines are due to the vaso-dilatation. Sometimes get white lines due to vaso-constrictor action. The former is the more serious.

The trunk is clear. There are some small spots like flea bites on the extensor surface of the arms, especially about the elbow. On the legs, the blotches are reddish; some are raised and capped with small blebs, like erythema iris. They are chiefly on the inner surface and above the left outer malleolus. They do not disappear on pressure. They are raised. They belong to the class of purpuric urticarias.

We saw purpura simplex before. This is purpura associated with gastro-intestinal symptoms. It is called Henoch's purpura. Characteristics:

1. Gastro-intestinal trouble—nausea, vomiting, colic, and diarrhoea coming on in spells. Not an uncommon accompaniment of purpura.

2. Liability to hemorrhage from the intestine or stomach and other mucous membranes. There may be albuminuria and nephritis.

These are not all separate diseases. In a few days this boy might return coughing and vomiting blood—in the extreme condition of purpura fulminans.

Sometimes one gets the gastro-intestinal trouble without the hemorrhage. Dr. Osler cited the case in town of a young boy with extreme colic and no other symptoms. The colic is due to the extravasation of blood into the submucosa of the gastro-intestinal tract. The edge of the spleen is just palpable. Examination of the abdomen is negative. The coagulation time is 5 min. Treatment: calcium chloride 20 grains three times a day.

Exophthalmic Goitre

P. 179. The cornea is exposed when she looks up. In von Graefe's sign when the eyeball is moved downward the upper lid does not follow it as in health. This sign is not constant and is not shown in this case. When she looks up to the ceiling the forehead is not wrinkled as it is in most normal people. Convergence is not good. There is a marked tremor. Heart is rapid. Hemic systolic murmurs are heard over the chest. The thyroid is not very much enlarged.

DISPENSARY CLINIC

NOVEMBER 24, 1896 — DR. OSLER

Potassium Iodide in Syphilis

In the syphilis case shown November 18 (see p. 44), the rash has now almost disappeared and the pain is gone. The periosteal nodes are disappearing. William Wallace (1832) of Dublin studied the action of potassium iodide in syphilis. His articles appeared in *The Lancet*, 1835-36. Record used 40 grains of potassium iodide for a dose. This drug was first used in syphilis by an Italian in 1820. Otis gives 60 grains per

diem in cerebral syphilis. W. H. Henry in 1870 gave 300 grains per day with good results. H. C. Wood finds no advantage in going beyond 240 grs. Syphilitics have a marked tolerance to the drug; iodism being rarely seen. The enormous doses are never employed in Europe. One does not get the good results in certain brain cases unless the maximum doses are given. It is good practice to give 60 to 70 grains in cerebral cases. Osler recently saw a case reported in which the patient took 900 grains per day. Above a certain quantity, say 240 grs., the excess probably fails to be absorbed and so exerts no action whatever.

Aortic Insufficiency

Michael Brehem, 63 years, Moulder (stone). He comes complaining of cough and a great deal of pain. He coughs chiefly at night. He has had the cough seven months or so, but it is growing worse. He has been a healthy man. He had the grippe six years ago. He never had rheumatic fever. Drinking whiskey before breakfast south of Mason and Dixon's line is not such a grievous sign as north of the line, as in the Southern states some take their only drink before breakfast. He is a temperate-looking man. The family history is good. His wife and seven children are well. His eyes are clear. There is no arcus senilis. The pupils are equal. No distended venules are present on the cheek; there are a few on the nose. No tophi. We should have asked him more in regard to his work. He had much lifting and straining to do. His pulse is soft and full. You can see both arteries of his wrists, and a pulsation is visible in the radial. It is a full regular pulse. One ought not to see the radial artery in a well-nourished man. Pulse 70, very regular. It is very jerky and on compression is still seen; that is, it is recurrent and anastomotic.

Scars of the wet cups are seen on his chest. He had pneumonia when he was 20. Clavicles stand out. The sterno-mastoids are prominent. There are visible pulsations in the carotids; slight in the subclavian. There is no marked visible cardiac impulse. There is no bulging of the praecordia. His chest moves up, rather than outward. *This is common in an*

old man. It is an old man's chest. His back is little bowed. The spine is straight. There is no particular difference between the two sides. One can feel an ill-defined cardiac impulse in the 5th interspace, just below the nipple. In health one may feel the sounds and the shock of the sounds in the region of the apex beat. I do not feel the first sound over the heart; only a dull thud. You have a feeling as if the whole sternum moved slightly. No abnormal murmurs are heard over the chest. Light percussion over the heart is clear. This is due to emphysema. A lappet of lung is over the heart. The sternum is resonant. At the apex there is a soft systolic murmur. In the aortic region there is a loud systolic murmur propagated into the vessels of the neck. It is very intense at the second right costal cartilege. There is here a loud diastolic murmur occurring with the second sound, not obliterating it completely. The second sound is quite ringing. There is a pulsation in the aortic region which is suspicious. He has aortic insufficiency and comes complaining of cough. We have seen two cases of aneurism, coming with cough, and this may be an aneurism. He is not the type of man we meet with in aortic insufficiency. They are larger, more muscular, but he, like them, has worked hard and taken much alcohol. Most of them have had syphilis. This pulse is called a Corrigan pulse. Aortic insufficiency is often called Corrigan's disease.

AMPHITHEATRE CLINIC

NOVEMBER 25, 1896 — DR. OSLER

Note particularly ulcers of the large interestine. It is a neglected subject.

Amebic Abscess of Liver

The patients with amebic dysentery shown two weeks ago are nearly well. They may not remain well even when diarrhea stops, amebae disappear, and there is a gain in weight. Some amebae stick for months (even six months) around the base of the ulcers. After being well for several months they may

come in with an entirely different set of symptoms—fever and other symptoms of abscess of the liver. We see 4 or 5 cases a year here of abscess of the liver.

An old man, 65, Sam Creak, Colored. He was admitted October 4, 1896, complaining of frequent movement of the bowels. He stated that he had always been healthy. He once was a hard drinker. He never had an attack like the present. His illness began in August 1896. He has pain in the bowels, with frequent griping pain and numerous small movements each day sometimes watery, containing blood and mucus. He was a debilitated, feeble old man. Bowel movements occurred every 10 minutes. The examination of his abdomen was negative except for a little distention and tenderness. Examination of the thoracic organs was negative. There was no especial anemia. Few amebae were present in the stools; none found at first. He had a low temperature, often down to 95°. The range between October 24 and November 4 was 95° to 100°. Dysentery is one of the diseases in which we have a very low temperature. Between November 5 and 11 he developed an extremely irregular temperature, which should have attracted our attention. A more systematic examination should have been made. One day (Nov. 8) he had a temperature range from 99.4° to 104°. No chills. Bowel movements kept up in spite of the irrigations until the 13th when quinine was changed to the nitrate of silver but no improvement was noticed. He became very dull and stupid. He died at 3:00 a. m. on the 20th.

It is interesting to note that the liver was not increased in size. Neither in weight or size did it exceed the normal. At autopsy, two fluctuating areas were noted; one to the right, the other just to the left of the suspensory ligament. The one on the right was the size of a small apple. It was separated from the capsule by 1 cm. of liver substance. There was nothing on the surface of the liver to denote where the abscess was located. *Surgeons should notice this.* In the left lobe there was an abscess of slightly smaller size, full of this creamy glutinous material, surrounded by injected liver substance. This is very common. Abscesses of the left lobe may perforate into

the left lung or pleura or into the pericardium. This is not a bad way for it to perforate. The majority of abscesses are single. Note: 1) Here are two abscesses; 2) The liver is not enlarged; 3) Had the abscess in the left lobe perforated it would have entered the right lung.

We can understand the irritation he had in the rectum by examining the intestine. Ulcers occur down to the internal sphincter. Above these is a band of mucosa; the second inch of rectum is clear; the third inch is much eroded; the bases of the ulcers are much infected. Pain, tenderness and frequency of movements in dysentery are directly in proportion to the involvement of the rectum. There is much ulceration, mostly fresh, throughout the entire colon extending to the ileocoecal valve, and much congestion. In the coecum and ascending colon the ulcers are quite numerous, more than in the middle of the colon. Remember that this case of abscess of the liver was not recognized clinically.

Typhoid Fever

The relapse cases shown last week are doing well.

Case XVII. Relapse Case With Perineal Abscess

Hebble (p. 60). In this case the relapse was much more severe than the primary fever. It is now the 22nd day of the relapse and the temperature is not normal. As a complication this patient has a perineal abscess.

There are two types of bed sores. The first is due to direct, long-continued pressure on parts of the body and necrosis follows. Very sick patients may lie for days in one position. The second type occurs in severe cases with pronounced nervous symptoms. In these bed sores may develop early. The patient lies low in bed like a log. One sees cases of this type in perfectly well-nourished individuals. They are trophic in origin rather than due to prolonged pressure. Cases of this type are not the fault of the physician or nurse. This patient has a bed sore over her sacrum. This is the most common situation. One

on each heel is due to persistent pressure. Her heels are now almost well. She was first shown October 14. Then the sloughs were black. This is the only case of bed sores we have had this fall. The more careful the nursing, the fewer the bed sores. The patient and the disease are responsible for one-third of the bed sores; the doctor and nurse for the other two-thirds.

All the other typhoid cases are doing well. The little girl, our most severe case, is recovering.

Syphilis

The man (see pp. 44, 53, 68) in the isolation ward has been treated for one week with mercurial inunctions. The pain in the clavicle has gone, and the eruption has disappeared. The induration still exists. It may persist a very variable length of time.

Postdiphtheritic Paralysis

The little child with diphtheritic paralysis presented at the November 11 Clinic (p. 39) was shown again. He has a marked lordosis and the abdomen protrudes. He is unable to get up when seated on the floor. When shown before, he had ataxia and disappearance of the knee jerks. Now his head is loose and his neck is flabby. Before, water regurgitated through the nose when he drank; now he has difficulty in swallowing solids, suggesting an involvement of the pharyngeal muscles; a not very uncommon occurrence. This child ought not to be running about. It really puts his life in jeopardy. A diphtheria patient with any signs of paralysis should not be up and about. Death may occur with great suddeness. Interstitial myocarditis is thought to be the cause.

DISPENSARY CLINIC

DECEMBER 1, 1896 — DR. OSLER

A typhoid fever patient just seen on the 14th day of the disease has been doing well, but now has a chill. Chills may

appear: (1) at onset of the disease; (2) at onset of relapse; (3) as a result of drugs; (4) as a result of complications such as phlebitis; (5) late in the disease due to septic infections; (6) combined infections.

Syphilitic Convulsions

Swedor (1788) first described convulsions in syphilis. Todd in 1855 insisted on headache as diagnostic of cerebral syphilis. That was Robert Burtley Todd. His clinical work is very valuable. He was one of the first to describe accurately locomotor ataxia. He was one of the great clinicians of the middle of the century.

The syphilitic convulsion is not the sudden drop of epilepsy. It is more like Jacksonian epilepsy. Syphilitic convulsions come on from one to sixteen years after the primary lesion. They last from 20 to 30 minutes. There is softening of the brain around the gumma. The age is usually from 20 to 30. Fournier says epilepsy after thirty years of age is due to syphilis. Wood says a sunstroke may bring on the first convulsion. Convulsions may come on within a few months after the primary lesion; one case was reported after 2 months and 8 days. Fournier says syphilitic convulsions are Jacksonian in character.

Aneurism of the Arch of the Aorta

Fred Buliver (pp. 27,.98, 107, 114). Since last Sunday he has been worse. His cough is bad and he does not sleep well. He was seen here on October 27. No pulse can be felt in his left radial artery and none in his left carotid. The loss of the radial pulse might be due theoretically: (1) to a thrombus; (2) to a tumor pressing on the artery. Dr. Osler thinks a very slight pulsation is to be felt in the radial artery but it is not visible. No pulse can be felt in the left carotid. The channel in an aneurism may be very small and irregular. A partial thrombus might produce this diminished pulse in the radial artery.

Inspection: Bulging of the second and third costal cartilages

is noted. This is of no importance. It might be caused by rickets in childhood. There is a diffuse pulsation between the second and fourth ribs on the left side. A distinct impulse is felt when the hands are placed one on the chest the other on the back. At the cardiac apex a slight systolic murmur is heard and also along the left sternal border. From the left clavicle to the fourth rib, there is a blowing systolic murmur, which is quite intense. It is short and sharp, and of maximum intensity over the manubrium. There is no loud intense accentuated aortic second sound. No diastolic shock. A very intense bruit is heard in the right subclavian and carotid. There is a diminished resonance over the manubrium. This is important. The pulsation in the right subclavian and carotid is not so intense as when he was last examined.

Oliver's tracheal tugging. This was wrongly ascribed to Surgeon-Major Porter in the first edition of my text book. It is marked here. The symptoms present in this case are: (1) pain in the chest; (2) shortness of breath; (3) bronchitis. He has important signs of a tumor of the arch of the aorta compressing and involving the bronchus.

Rheumatoid Arthritis

John O'Halleran (p. 49). This case of rheumatoid arthritis was seen some weeks ago. His feet are not nearly as swollen now but are still somewhat oedematous. He looks much better than when last seen. He say that he has followed out faithfully the treatment recommended.

AMPHITHEATRE CLINIC

DECEMBER 2, 1896 — DR. OSLER

Case XVII. Typhoid Fever. Relapse Without a Period of Apyrexia

Hebble (p. 57). The original attack of typhoid fever lasted 22 days; his relapse 26 days. He had not an entire day of apyrexia between them. Remember that *the relapse here* was longer and more severe than the original attack.

Case XVI. Typhoid Fever

Anne Andor (pp. 48, 72). In the clinic two weeks ago I spoke of this case. The temperature fell to normal on the 41st day of her illness. This was a very serious case. There was cardiac failure and anemia. It was the worst case we have had this fall. On the 42nd day the temperature was normal only part of the time; fever on the 43rd; none on the 44th. Since then she has had fever every day—a continuous fever. Now in the 55th day. She had three days of normal temperature, we will say. Relapse dates from the 41st day. No guarantee even when the fever is of very long duration that there will be no relapse. The longest interval we have had between the original attack and the relapse is 42 days.

Case XVIII. Typhoid Fever with Cholecystitis

Mrs. Dehl, age 54 (pp. 71, 177). The oldest typhoid fever patient we have had. At onset there was soreness in the throat; later headache, pain in the back, and vomiting. Notice there was a good deal of gastric trouble at the outset. Bowels are somewhat constipated. No nose bleed. Fever at times has been up to 104°. She has had 39 baths. The temperature is now between 102° and 103°. She has been mentally rather dull and heavy. There is no delirium. There is a very feeble pulse. The abdomen is a little distended. Doubtful about rose spots. Her blood shows the Widal's test well. In this test when positive the typhoid bacilli collect in clumps. November 30. Pain in the right side of the abdomen. There was distinct tenderness in the right hypochondriac and right iliac regions; in fact she was exquisitely sensitive. She vomited twice on Nov. 30. The sensitiveness under the costal margin kept up for several days. We suspected trouble around the gall bladder. Yesterday she had a distinct yellow look. It is not so marked today. Bile is present in the urine. Any hepatic trouble, jaundice particularly, in typhoid fever is very rare. Dr. Osler thinks she has had a cholecystitis. Typhoid bacilii persist a long time in the bile passages.

A nurse here recently had acute suppurative cholecystitis. It was mistaken for peritonitis and operation for this was undertaken. She was supposed to have a ruptured appendix.

Case XIX. Pneumo-Typhoid

Patrick Donahue (p. 72). He complains of a general aching. He was admitted on the 4th day of his illness. His mind is clear; there is fur on his tongue; the skin is hot and dry. He was restless in bed. The expansion of the chest was less on the right side. On auscultation the sounds here were harsh. Crackling rales were heard at the end of inspiration. There was general pain and tenderness over the entire abdomen, and a marked leukocytosis. It is the only case of typhoid fever we have seen for a long time with a leukocytosis. Widal's test gave clumping of bacilli. On entrance there was a suspicious deficiency of resonance over the back. This increased and there is now marked dulness on the right side and tubular breathing. Vocal fremitus was increased. He has had a low type of fever. No expectoration. No cough. No respiratory distress. His general condition is good. The question was whether he had an anomalous pneumonia or typhoid fever. The spleen was not palpable. The pneumonic symptoms early in typhoid fever are not the frank symptoms of true pneumonia. The appearance of the patient is not that seen in pneumonia. He lies low in bed. The facies is that of typhoid fever. The cases with sharp pain, shortness of breath and rusty sputum with pneumococci are the cases that one mistakes for simple lobar pneumonia. Some mistakes will occur in differentiating acute pneumonic phthisis and lobar pneumonia, and there is no way of avoiding these mistakes.

Case XX. Erysipelas in Typhoid Fever

Luckar, age 19 years (p. 71). Now in the 11th day of his disease. Temperature satisfactory. It has only once reached 105°. There is acute swelling of the nose with redness of the bridge of the nose extending out on the cheek and down on the

lip, looking much like erysipelas. It has the butterfly look. Rose spots are present over the abodmen, back, on the face, and on the legs down to his ankles. We have each year two cases or so with spots everywhere; usually they are in children. For the redness of the face use cold (*ice cold*) compresses. Erysipelas in typhoid fever is not a common complication.

Chlorosis

Kate Schultze (pp. 71, 84, 101). She has had chlorosis for some months. We can be almost certain it is not her first attack because it is so severe. The hemoglobin was 33% on admission; red corpuscles 2,600,000; leucocytes 6,000. Hence no leucocytosis. In the four days since admission there has been a slight increase in hemoglobin and a slight decrease in the number of red corpuscles.

Nearly all cases are easily and readily cured, but we cannot prevent a relapse. Most cases are in girls who have to work hard. Poor air, poor food and poor digestion are the important causal factors. Menstrual irregularities follow often; a sequence, not a cause, of chlorosis. Sir Andrew Clark and others think constipation causes chlorosis. If so, chlorosis would be a most common disease. But constipation is one of the features of the disease and must be combated. There are many ways of treating the disease. Bringing the patient into the hospital, quiet, rest in bed fresh air, plenty of food and an occasional laxative are all of value. Compound tinture of cardamon is used, 20 minims three times a day. It is a specific as it combines the three essentials—color, taste, and harmlessness. This is often used when no medicine is needed. The patients with chlorosis are always fat and pasty-looking. Her feet are swollen and she is slightly oedematous. Chlorosis is often imstaken for Bright's disease, owing to the puffiness. It is easy to get the hemoglobin up to 80% but difficult to get it up to 100%.

DISPENSARY CLINIC

DECEMBER 3, 1896 — DR. OSLER

Arthritis Deformans

Adams (1857) demonstrated the pathological changes in arthritis deformans. Charcot (1880) says in chronic rheumatism the deformity is not as great as in arthritis deformans and gout. It is distinguished from gout by the absence of urates. Creaking on movement is often well-marked in arthritis deformans. In arthritis deformans the joints are involved symmetrically. In gout the joints are affected asymmetrically and not equally. Charcot considers that the muscular contractions in arthritis deformans give rise to the deformity. Later the muscles waste and fibrous ankyloses are found; this is especially true of the interossei muscles. In Charcot's work on diseases of old age there is a very good description of arthritis deformans. But Adams' work, however, is the classic.

Corrigan pulse. Sir Dominic Corrigan was born in 1802 and died in 1880. Trousseau was the first to speak of the water-hammer pulse in aortic insufficiency as Corrigan's pulse. Corrigan's paper which contained the description of the characteristics of this pulse was published in the Edinburgh Medical and Surgical Journal in 1832. It is a bounding rapidly collapsing pulse, and is often visible. The French call aortic insufficiency the *maladie de Corrigan.*

Syphilis

Mary N., age 31. She complains of pain in the right eye. Duration one week. Her mother died of tuberculosis of the lungs. The patient has been well. She has been married nine years and has had three children. Her babies were all well at birth. Two died of legitimate causes. Her husband died four years ago.

Three weeks ago she was seized with chills. Then eruptions appeared over the body, beginning on the face and there was fever. There are no sores in the mouth. The right eye began

to pain her a week ago. It pains her mostly at night. There is a rash on the forehead and generally over the face except the cheeks and just under the chin. Most of the lesions are solitary but some are in groups; seven in one group. They are raised papules. They are scattered over the chest. Plenty are present on the back of the neck. On the arm they are flatter and smooth patches are seen capped with little scales. The papules are numerous on the inner side of the thighs. On the legs they are very abundant and larger. They are hard and firm. The color is usually a little red and some of the papules are capped with brownish scales. Her facies is a little suggestive of congenital lues. Note the saddle nose. Her right eye is partially closed. She has acute conjunctivitis and acute iritis. In this case the rash is papular and semi-squamous. The other day we saw the macular, measly rash. From the skin of the forehead alone we could not say what this is. It might be the papular rash of smallpox. The eye before long will probably present an example of the pustular rash of syphilis.

Periostitis After Typhoid Fever

Bessie Massey, 20 years (p. 146). She was discharged from Ward O one month ago and now comes back with pain in the left arm. She points to a painful spot about the middle of the upper arm. There is well-marked tenderness on deep pressure over the shaft of the humerus. In the hospital she had tenderness of the left arm, and has not been able to straighten it since then. The resistance on movement is distinctly muscular. This condition points to trouble due to the typhoid bacillus. It usually begins as a circumscribed periostitis but it may extend to the bone and cause osteomyelitis. The resulting osteomyelitis may be severe with sequestrum formation. Although she is not able to extend fully the left arm, she says she has no pain in it.

RECITATION

DECEMBER 5, 1896 — DR. OSLER

Reinfection in Syphilis

This is a very difficult matter to determine as the patient's statements must be taken with bushels of salt. Ninty-nine cases in all of reinfection in syphilis have been reported. In 61 there were no secondary symptoms. In 9 seen by the same men all had secondary symptoms and some had tertiary. Jonathan Hutchinson is the only one among English syphilographers who believes in the unity of syphilis and soft chancre. Many hold that syphilis is never cured. Parasyphilitic affections are paresis and locomotor ataxia.

Senile Tuberculosis—Autopsy

The lungs were demonstrated from the autopsy of a case of rapid tuberculosis. This man was 75. Note that as unusual. It was formerly thought that pulmonary tuberculosis in old age was very uncommon but it is now known to be more common. In the *Revue de Médicin* for 1896 there is an article on senile tuberculosis. In the upper part of the left lung, there is a firm consolidation. It is the caseous pneumonia of *Laennec* and comes under the heading of acute tuberculous pneumonia. The consolidation occurs rapidly. This form is not so very common. It is often mistaken for acute pneumonia. Dr. Osler cited the case of a young Irish cab driver, exposed on a cold night until three o'clock in the morning. He was admitted to the University Hospital in Philadelphia as a case of lobar pneumonia. Ten days later tubercle bacilli were found in his sputum. (Case described in Osler's Textbook, second edition, p. 231.) This man today has evidence of old pleurisy which may have been tuberculous. There is an old pleurisy of the other side too. There is also the puckered apex of an old tuberculosis. It is a fibrous area. Do not say healed until the area is calcified. A small cavity was demonstrated. Dr. Osler said that small cavi-

ties like this give signs that are very deceptive. The breath sounds may have a very amphoric quality. We may have pseudo-cavernous signs. A case was operated upon here for supposed abscess of the lung. A small cavity existed but not the large one we expected to find. We had been mislead by pseudo-cavernous signs.

Aneurism of the Innominate Artery

Richard Lee, colored, age 36 (p. 69, 75, 115, 150). He has dyspnoea. Expiration is louder than inspiration. There is marked stridor with wheezy, jerky breathing. His chest seems almost fixed. The abdominal movements are marked. Every few minutes he coughs. The veins of his neck stand out prominently, particularly during expiration. To examine for imperfect oxidation in a colored person inspect the nails, tongue and lips. His fingers look a little dusky. His " cold " began 60 days ago and has been growing worse. Onset with sore throat. Has " misery in the throat." Worse two days ago.

He had the usual children's diseases. Gonorrhea, 3 times. He had the primary lesion of syphilis 10 years ago.

The chest is well shaped. The sternal notch is filled out. The apex impulse of the heart is below and inside the nipple. There is marked fulness about the neck; more so on the left side. There is no abnormal pulsation. The back is examined. The muscles are prominent. The veins over the chest are now seen to stand out. Respirations 36. The pulse is steady and strong, regular; tension good, not much increased.

He has not lain down for six weeks (orthopnoea). The sternal notch is filled up by a distinct glandular mass which is tender on palpation. It runs under the left sternomastoid, and up to the cricoid. There is swelling to the left also. The mass is rounded and movable. It does not pulsate. It is rather suspiciously movable for a tumor in this situation. There is no enlargement on the right side of the neck. The glands in the posterior cervical triangle are only a little enlarged over the trapezius. Examine now the thyroid cartilage. The thyroid is not enlarged. There is no infiltration in the thyrohyoid

membrane. The box of larynx is freely movable. Now examine the throat. Note that the voice is not affected. The tongue is a little swollen, and an erosion is present. The percussion note is flat over the upper part of the manubrium, and is not as clear and resonant as normal over the upper part of the back. The heart sounds at the apex are quite clear and also at the base. There is no accentuation of the second sound. Everywhere over the chest in front loud snoring tracheal breath sounds are heard. Fine crackling râles are present at the end of inspiration. The natural vesicular murmur is entirely cloaked by these rough sounds. Expiration is much prolonged. Behind too there is rough, harsh, snoring breathing. Fine crackles are heard at both apices.

The two objective phenomena are the swelling in the suprasternal notch and the lung signs. It may be thyroid. Aberrant portions may be anywhere from the base of the tongue to the arch of the aorta. Here is a distinct tumor mass. It has a marked pulsation, by the way. The middle lobe of the thyroid may pass down under the manubrium. His larynx should be examined. Syphilitic laryngitis frequently causes stenosis.

DISPENSARY CLINIC

DECEMBER 8, 1896 — DR. OSLER

Syphilitic Periostitis

Bone lesions (see p. 44, 53, 58) may appear at the beginning of the secondary stage of syphilis. The pain varies, being present in all degrees. It is like that in rheumatism. It shifts from one joint to another. The disease is in the periosteum. The gummata of secondary syphilis are smaller, more numerous and more readily cured than those of tertiary syphilis; in all other points they are alike. Periostitis rarely occurs before the 4th month; usually in the 6th month after the initial lesion. The exostoses do not appear before the fourth year.

Our case is very unusual. He was infected July 4; he came to us November 17 and had the pain in his clavicle for six weeks before that date.

Aneurism of the Innominate Artery

In September, 1894, Richard Lee (pp. 67, 75, 115, 150), the patient shown at the last clinic, was at the University Hospital in Philadelphia where he was operated on for aneurism of the thigh by Dr. Martin.

His throat was clear but he has paralysis of the vocal cords. As he breathes in and out, the vocal cords are as wide apart as possible. The tumor was distinctly pulsatile. We did not pay enough attention to this. On Saturday night and Sunday he was very bad. He had orthopnoea of the severest type. It was decided that it was an aneurism of the innominate. It has probably pressed the trachea to the left, and, secondly, has compressed it. Dr. Bloodgood was consulted. An operation was not advisable. We do not even think he could take the ether. It was suggested that the end of the clavicle and the manubrium should be excised to relieve the distress. But these aneurisms by extension frequently include bone in the lining of the sac; so we might cut into the aneurism. Yesterday he was not so bad until evening when the respiration became perilous. He became cyanosed. In this condition bleeding was indicated. He was bled actively last night and was better at once. The tension of the blood was much reduced. Today he feels much better. Twenty ounces of blood were withdrawn.

There is no doubt that this is an aneurism. Saturday we thought it might be a glandular swelling. Look up the question of multiple aneurisms. See Neal's *Medical Digest* published by the New Sydenham Society. It is very good for English references

Last night his temperature went up to 105.5°. That may be due to lobular pneumonia caused by pressure. He has a chronic bronchitis. Pneumonia or a pericarditis as a terminal infection often carries these cases off. In this case tracheal tugging is feeble. This aneurism is probably much larger than it appears, because the signs of compression are so marked. But an aneurism the size of a walnut may produce orthopnoea of the most severe kind. The aneurism with physical signs may

have no symptoms whatever. This is one of the most urgent cases we have seen. It is sometimes difficult to decide where the pressure is exerted. Often tracheotomy has been performed when the obstruction was below; its true nature being overlooked.

Catarrhal Jaundice

William Friedy, age 23; tailor. The skin is not sallow. His complexion is yellow; not only the face but there is a well-marked yellowish hue to the sclera also. He complains of cough of a year's duration and headache for four or five months. He complains of nothing else. There is no digestive trouble. His family story is good and also his past history. A week ago he was seized with fever and the yellow color was first noticed at the same time. He had nausea and vomiting which were slight, and came on insidiously. No other members of his family are jaundiced and there are no cases in the neighborhood. Ask this of patients because jaundice sometimes occurs in crops. In our 1000 cases of malaria this tint never occurred even in the "yaller chills." His bowels are irregular. He has not lost weight. It is important to ask this.

He is of moderate build; healthy looking; his lips are of good color. It is a yellow, not a bronzed, jaundice. Always notice whether the liver is below the costal margin or not, as the normal lower border is at the costal margin. Always note the presence of abdominal breathing. The costal grooves are equal; the iliac grooves are equal and the side lines are equal.

Litten's diaphragmic sign has been seen since Hippocrates' time, but it passed unnoticed until a few years ago. It is a movable horizontal depression on the lower part of the sides of the thorax seen is respiration.

Feel for the edge of the liver. It is difficult to feel the left lobe as its edge is so thin. There is no pain on palpating the liver. The spleen is not palpable. Examination of the abdomen is negative. The upper border of the liver is at the sixth rib in the nipple line. This is normal.

He is a man of good habits. He has had no chills. The his-

tory of indigestion of a week's duration and the absence of pain point to catarrhal jaundice. Give him salts and six weeks.

AMPHITHEATRE CLINIC

DECEMBER 9, 1896 — DR. OSLER

Chlorosis

Kate Schultz (pp. 63, 84, 101). Her blood is creeping upward and onward. The red blood corpuscles have gained a little but there is no increase in the hemoglobin. She is having simple good hygienic treatment; no iron. She has been out only two or three hours daily. She should be out all the hours that the sun shines; 7 or 8 hours a day if possible.

Case XVIII. Typhoid Fever with Cholecystitis

Mrs. Dehl (pp. 61, 177). The case of cholecystitis shown last week is distinctly better. Cholecystitis as a complication in typhoid fever is rare. There have been only three cases here since the hospital was opened. A case in which typhoid bacilli were found in the gall bladder six months after the attack of typhoid fever is recorded in Volume 1 of Charcot and Bouchard's *Traité de Médicin.*

A nurse last year, during convalescence from typhoid fever, had two attacks of colic. Several months after the typhoid fever she had recurrent attacks. In the fall, 6 or 7 months after the disease, she was operated on by Halsted. Cholecystitis was found with the colon bacillus present in the cultures.

The longest interval between the original attack of typhoid fever and a relapse is 40 days, according to Nichols of the senior class who looked up the literature.

Case XX. Typhoid Fever

Luckar (p. 62). He has a fresh rash today, and it is universal which is extraordinary. The profuse erythema that looked as if erysipelas was appearing has entirely disappeared. Had his 54th tub this morning. He has no diarrhoea. The

only symptoms are the fever and tender toes. These must be associated with the baths. Dr. Bloodgood noticed them in a case where the continued bath was employed.

Case XXI. Typhoid Fever with Hemorrhage

Joseph Hering, tailor (p. 85). Admitted Saturday, December 5 on the 13th day after stopping work. He took purges before entrance. These cases as a rule do badly. There were rose spots, four or five, on the abdomen when admitted. The spleen was palpable. He was given on the 14th day of illness on litre of hot water per rectum for suppression of urine. An hour after that he had a bloody movement; considerable blood was lost but no change in temperature followed. He is pretty ill.

Case XIX. Typhoid Fever (Pneumo-typhoid)

Patrick Donahue (p. 62). Throughout the last week the temperature has been steadily falling. On the 7th there was still a little distention of the abdomen. A friction rub was heard in the right axilla. We thought it might be an effusion, but only blood was obtained on aspiration.

Case XVI. Typhoid Fever

Anne Andor (pp. 48, 61). She is convalescent. Her temperature is normal. This young girl had a very severe attack.

Erysipelas in Typhoid Fever

A report was read by Mr. Louis P. Hamburger of the senior class. Erysipelas is now an uncommon complication. Liebermeister states that it occurred in 0.7% of the cases of typhoid fever. Formerly it was very common. In 1849 and even earlier it appeared frequently at the Charité in Paris. In most of Louis' cases of typhoid fever erysipelas occurred in epidemics. In our 500 typhoid fever cases there has not been a single one of erysipelas.

Pneumonia

We have previously seen only one case this season. That was Goldie Flaherty (p. 31). Resolution usually begins with the crisis. The exudate is softened. Some is expectorated and some absorbed by the blood vessels and lymphatics. Sometimes expectoration ceases with the crisis. In other cases the exudate is largely cleared up by being expectorated. Delayed resolution sometimes occurs. This is very trying for the physician. The lung may be as solid at the end of 6, 8, 10 or 14 weeks as during the first few days. Even these late resolutions may leave the lung in perfect condition. The things to be feared are: (1) organization of the exudate, and (2) abscess formation, this is rare.

Case II. Pneumonia *

John McCarthy (p. 154). Two of his sisters died of tuberculosis. The present illness began six weeks ago with a heavy feeling and severe pains in the joints. Pain was present over the whole side. Expectoration has been yellow and white; rarely brown. He coughed up blood. It was coffee-colored. The patient gave up work 3 weeks before admission. He has lost 30 pounds.

There is an intense friction murmur in the right axilla. Dulness from apex to base over the right lung behind with tubular breathing of the most intense quality. No râles. The sputum is very agglutinous and rusty colored. Temperature 101.6° on admission, highest since then 102°.

Osler does not think it is a tuberculous consolidation—the tubular breathing, the expectoration, the dry friction sound—all point to pneuomnia. In the case Osler saw of pneumonia of 14 weeks' duration entire resolution followed.

Case III. Pneumonia

J. Armstrong. Admitted a week ago today. He complained of pain in the left side. The patient waked up with pain in

* The corrected diagnosis was acute pneumonic phthisis.

the left side and was later seized with a chill. He stayed in bed all day, then came to the hospital. The next morning after admission his expression showed he was suffering pain. An expiratory grunt was present and that also suggested pain. There was almost complete consolidation of the left upper lobe. Extremely fine râles were heard on inspiration. They were 1) not increased on coughing and 2) were very superficial. Hence it was thought to be pleural. A few casts were found in the urine, but when urine is centrifugalized some are always detected. On December 6, his temperature fell at 2:00 a. m. On December 7, the temperature was 97°; pulse 80. It was thought then that he was having a crisis, but by 4:00 p. m. the temperature had risen to 104°. Before the fall an area of dulness was made out in the right back. Yesterday morning the temperature had fallen to 101°. There was a steady fall all day with a slight rise toward morning. He is having his crisis. Leucocytes have been increased until this morning when they fell from 22,000 to 12,000. The pseudo-crisis in this case is very interesting. The cause is not understood. Cases are seen with intermittent temperature. These were formerly called malarial pneumonia, but they have nothing to do with malaria. We see cases of pneumonia in malarial cachectics. The fever *is apt to be severe but is no more apt to be intermittent than* in any other pneumonia. In this case the presence of leucocytosis was a favorable sign. Few cases without leucocytosis recover. Sometimes the fall of leucocytes comes before the crisis but usually the crisis comes first. The upper left lobe gives Skoda's resonance. This occurs over a relaxed lung.

DISPENSARY CLINIC

DECEMBER 12, 1896 — DR. OSLER

A report on "Multiple Aneurisms" was read by Arthur W. Elting of the third year class. In Pellington's case there were 63 aneurisms. A supplementary Heft of Langenbeck's *Archiv* contains Eppinger's article on congenital aneurisms. This case

of 63 aneurisms was probably of congenital origin. Thomas King Chalmers' case was particularly interesting. He died about 10 years ago.

Pressure Symptoms of Aneurism

The pulmonary and bronchial symptoms of aneurism are very interesting. The pressure causes a long series of signs and symptoms beginning with diffuse changes; later a catarrhal condition develops. ("A small aneurism from the lower or posterior wall of the arch may compress a bronchus, inducing bronchorrhoea, gradual bronchiectasy, and suppuration in the lung." Osler, Textbook, 2nd edition, p. 708).

Richard Lee (pp. 67, 69, 115, 150) is about the same; his temperature went up, due to patches of bronchopneumonia that are appearing.

Stomatitis

Edward Girspy (p. 89), aged 12. He comes in with fever and a swollen tongue. His voice is a little muffled and nasal. He looks pale and ill. His external glands are not enlarged, except those at the angle of the left jaw which are slightly enlarged. There is little mucus from nose. He can not open his mouth widely. His tongue is a little swollen, and somewhat coated. It is a plastic tongue. The fungiform papillae are enlarged. The tongue can protrude only 2 cm. beyond the teeth. The middle of the tongue feels hard and indurated. There are not patches in the throat, but a great deal of mucus is present. His gums are uniformly white, a little swollen, and covered with a whitish material that can be washed off. There is no special fetor. It looks as if he had a stomatitis. Give 5 grains of chlorate of potash and some aconite. Chlorate of potash is an interesting drug. It is quite poisonous even in medicinal doses. It produces nephritis. It used to be given in too large doses. The patient says a good deal of saliva dribbles from his mouth. We see more cases of mercurial salivation now with small doses of calomel than we did years ago with large doses. This looks like mercurial stomatitis but he says he

has not taken any medicine. But there is in this case no fetor; this is pronounced in mercurial stomatitis. He has been sick 3 days.

Rx.	Potassii chlorati	gr. v
	Aconiti	Mi

Sig: Give this dose every four hours until 8 doses are taken

Erythema Nodosum

Mrs. Miller (p. 43). She is decidedly better and looks better. She has taken the medicine regularly. She does not mind the taste of the medicine. It is calcium chloride. It has a salty taste and is better when taken with orange peel.

Chlorosis

Anne de Monte, age 17 (p. 82). Occupation—sewing. The higher the stairs the more chlorosis. Climbing stairs is very hard. She had to work in a crowded room. The air was bad but there was only one flight of stairs to climb. Her catamenia has been regular. It began between the age of 14 and 15; there is no constipation. She has had headache for a year. Brow ache is common in chlorosis. It is apt to be intermittent in character; it is the so-called ague headache. Her legs are not much swollen. They are greatly swollen only in extreme cases. The presence of swollen feet often leads to the false diagnosis of Bright's disease. She has palpitation of the heart. We should always ask if this is present. Chlorosis is sometimes mistaken for heart disease. There is a loud venous hum and a bruit at the base of the heart. The hemoglobin is 27%. In severe cases it is anywhere from 17 to 27%. A very loud venous hum is heard in the neck. She is getting Blaud's pills. His original formula is given in Niemeyer's *Practice*.

Her mother has a very ruddy color. This is a matter of capillaries. She has always been well.

Chlorosis

Mary Callihan. She complained first of a beating in her throat and then she could see the movement on the side of her neck. She has had palpitation and shortness of breath. There has been buzzing in her ears; now only in the left ear. She is constipated. There is a loud bruit over the heart with intensification of the second aortic sound. In the neck an intense venous hum is heard. It is a curious continuous humming murmur. Menses are not regular now. They were until two months ago when she first became ill. The irregularity of menses is a sequence rather than a cause of the disease as some have thought.

DISPENSARY CLINIC

DECEMBER 15, 1896 — DR. OSLER

Lead Poisoning

Peter Lynn, age 29, painter (p. 82). Complains of wrist drop affecting both hands. He has been weak in his arms for some time. He is thin. He has a bad taste in his mouth and no appetite. Three months and a half ago he had pains in his "stomach." They were colicky pains. In addition he had two attacks of colic each lasting a day and a half. There is some constipation. He has been a painter for 12 years. Another man in the same shop has had wrist drop for a long time. It is very rare for the paralysis to persist. The prognosis is good. He worked up to the 6th of November and came here the next day. His complexion became sallow. He has had wrist drop for only 7 weeks. He does not drink much. Alcohol and lead poisoning cause sclerosis. He has not now the Saturnic cachexia. It often takes a good deal of lead to produce poisoning; varying with the individual. Some can work all their lives. See Dr. Oliver's lecture on lead poisoning in the *British Medical Journal*, Vol. 1, 1891. Painters should be careful to clean their hands and nails before eating. This is lead neuritis. Another feature often met with is epilepsy. If you see epilepsy

in a young man, suspect lead poisoning. When brain symptoms such as delirium develop the condition is called lead encephalopathy. Here the blue line on the gums is marked. Burton noticed the lead line. It is absent when teeth and mouth are kept clean. Dr. Oliver saw the blue line the next day after a therapeutic dose of lead. There are two blue lines; one is a delicate line at the junction of the teeth and the gums and is easily removed. *The other is bluish-black. This is the true line.* It is intermittent when viewed with a lens, as the lead is deposited in the papillae. Lead can be taken through the skin as well as through the lungs, so Dr. Oliver thinks. The channel through which it is passed *par excellence* is the digestive canal. In one case the anemia was mistaken for malarial poisoning. Dr. Oliver is physician of the Royal Infirmary at Newcastle-on-Tyne.

The two chief internal symptoms of lead poisoning are: (1) colic and (2) constipation. Sometimes, instead of a persistent constipation, there is an intense enterocolitis. The waxy pallor is marked. The bones have sometimes contained lead and to this the anemia may be partly due. Nerve symptoms: (1) paralysis of the peripheral nerves affecting chiefly the extensors of the wrist; (2) less commonly the epilepsy; and then (3) more rarely the acute lead encephalopathy. There is interference with the elimination of uric acid. Tophi are often found in the ears. The routine treatment is potassium iodide and, in addition he ought to have massage of the extremities.

Varicella

Thomas Carey, age 4, 406 Durham Street. See he is all broken out. The eruption began Sunday. There was no fever and he was not sick to his stomach. Itching was the first complaint. There are small papules over the shoulders, chest and arms. There is one on the face and one on the lip. The distribution is chiefly about the trunk. The size varies from a pin head to a split pea. It is a papular vesicular rash which is in the process of drying. There is no question but that it is

varicella. It is the lightest type. Sometimes in chicken-pox the patient may have only two papules. In chicken-pox there are few on the face and hands, many on trunk and abdomen. No other disease runs the curious rapid course of the chicken-pox eruption. It may pass through as many of its various stages in forty-eight hours as the small-pox eruption does in two weeks.

Tobacco Angina

William Matthews, 39 years, bookeeper (pp. 125, 173). He has not worked since last February. He complains of pain in the chest when he walks or takes a full meal. The first attack was on July 1. While on a walk that day he was taken with sudden pain and severe sweating, and he had to grasp a post in order to support himself. Since then, when he exerts himself, he feels a throbbing over the heart. He has had rheumatism but it was not acute. He denies lues. He has been a very heavy chewer: Has consumed ½ lb. of tobacco a week for 16 years—a plug a day. He is a healthy, vigorous-looking man. Note the curious yellow infiltration below the right eye. This is xanthoma or xanthelasma. It is not very common in women and less so in men. Pulse is 68. It drops about every fifth or sixth beat. The apex beat is not visible and only feebly palpable. The shock of the sounds is not felt. Both sounds are very loud and clear at the apex. Second aortic is not accentuated. The heart is perfectly normal on auscultation.

Those sensations about the heart are unquestionably due to the tobacco.* His attack last July was tobacco angina. Take

* Dr. Osler wrote in his Lectures on *Angina Pectoris and Allied States*, published in 1896, that he had seen but two cases "in which the severe paroxysms of cardiac pain appeared to be due to the abuse of tobacco." If my recollection is correct, this patient, William Matthews, died suddenly about a year after this visit to the Dispensary, indicating that the correct diagnosis was angina pectoris due to coronary disease and not tobacco angina. In this connection a quotation from the above-mentioned Lectures is pertinent: "One must be a professional Ulysses in craft and wisdom not sometimes to err in estimating the nature of an attack of severe heart pain. There is no group of cases so calculated to keep one in a condition of wholesome humility. . . . Mr. X has left you with the full assurance that his cardiac pains are due to overwork or tobacco, and you have comforted his wife and lifted a weight of sorrow from both by your most favorable prognosis. With what sort of an appetite can you eat your breakfast when a week later you read in the morning paper the announcement of his sudden death in the railway station?"

¼ a plug for four days—then stop. He lives in Chestertown, Md. Dr. Hines is his physician. Give strychnine 1/60 gr. three times a day, later increase dose to 1/30 gr.

DISPENSARY CLINIC

DECEMBER 19, 1896 — DR. OSLER

Chronic Tonsillitis

Ella Grob, 12 years old. She complains of cough. Note the groove on either side in the nipple line extending inward beneath the level of the xiphoid cartilage. It is very typical. This groove is diagnostic of adenoid vegetations. No especial bowing of the back. She breathes at night with her mouth open, and the breathing is then noisy. Has had a cough for years. She has not an adenoid facies. She does not look dull. The nostrils are rather thick and fairly wide. Granular pharyngitis is present. Both tonsils are enlarged. Loud snorting breathing often follows two shallow respirations. The third tonsil may fill up the pharynx above so a child has to breathe through its mouth. The pharyngeal tonsils may also be affected. Adenoids produce a curious apathetic dull look expressed by a peculiar facies . It is seen between the ages of three and eight years usually. Nine out of ten deformed chests are due to mouth breathing. Dupuytren in Paris and Jonathan Mason Warren in Boston were the first to call attention to this. Read *Shut Your Mouth and Save Your Life* by Kit Catlin. It was published by the Health Society of Boston.

Emphysema in children may develop an " old man's chest." The adenoids may give rise to inability to fix the mind upon any subject (aprosexia). The funnel-breast is caused by obstructed breathing due to adenoids. The only treatment of adenoids is to clear out the wall of the pharynx. The tonsils are also often enlarged and ought to come out. They are useless structures anyway.

Aortic Insufficiency

David Briscow, hod carrier, age 68. He complained of shortness of breath, with swelling of the abdomen. There is no swelling of the feet. He has been a drinker of gin. He has had gonorrhea but denies syphilis. He has a pearly arcus. He looks well nourished. He looks comfortable; there is no shortness of breath. The pulsation in the neck is very marked. The radial pulse is weak and irregular. Feel the artery when the pulse is obliterated. It shows that the wall is thickened. Radial and ulna pulse are both visible. There is fulness above the right clavicle and in the suprasternal notch. It bulges out the lower portion of the sternomastoid muscle. On inspection the apex beat can not be determined. His respiration is perfectly quiet and movements of both sides of the chest are equal. The swelling extends a finger's breadth above the clavicle. No thrill at the base of the heart; no shock of the first sound.

We did not at first notice in Richard Lee that the sternoclavicular articulation was lifted. That was a case of aneurism.

Determine the upper limit of cardiac dulness. Percuss cautiously over the manubrium. There is no dulness here. On auscultation at the apex of the heart a soft systolic murmur is heard, and quite a loud rough diastolic murmur which terminates at the first sound in a very positive shock. A systolic murmur is present at the base and a very loud, almost booming, diastolic murmur. This is propagated down the sternum and is heard well over the ensiform cartilage. It is very loud over the manubrium. No systolic murmur is heard over the pulsation in the neck but a loud diastolic is present. The first sound is heard softly at the base. The second sound is everywhere replaced by the murmur. The pulmonic second sound is not heard. There is probably no aneurismal sac present but simply a dynamic dilatation of the aorta in a case of aortic insufficiency. The heart and aorta and innominate are engorged with a double quantity of blood.

Milia

John Wesley York, age 34. Over the manubrium and front of the chest are discreet nodules, whitish in color; some have run together. They are hard and have existed for years. Some are comedones. Sebum is squeezed out of one. The others are the largest size of milia. They are really atheromata.

DISPENSARY CLINIC

JANUARY 5, 1897 — DR. OSLER

Adenoids

The subject of adenoids is discussed. The child often awakes with a snort. Osler saw a child 4 years old with a barrel chest and emphysema. It had a mass of adenoids in the pharynx. It is more common to get Harrison's groove in children who have adenoids than a barrel chest. Aprosexia is seen in mouth breathers. Dr. Guy's views are most important. He thinks the adenoid growths at the back of the pharynx interfere with the return of lymph from the brain.

Lead Poisoning

Peter Lynn (p. 77). He is feeling much better. He had one attack of colic before the wrist drop came on. He still has pallor. The first thing for which patients may consult you is the lead pallor. It is due to a toxemia. With no other symptoms present it may be mistaken for simple anemia. The blue line can still be made out on his gums although less plainly. The wrist drop is about the same.

Chlorosis

Anne de Motte (p. 69). She is much better. The shortness of breath is gone and her head does not ache. Previously she had pain in the back of the head. She does not have the weak feeling now. Hemoglobin a week ago was up to 50%; it is probably up to 60% now.

Anemia of Lactation

Mary Michael, 31 years old. Sick 4 weeks. Before that she had an alveolar abscess with headache, but that is better now. She has been nursing a baby and may have just the anemia of lactation. During pregnancy a very severe anemia may occur. Following the loss of blood at parturition there may be a post-partum anemia. This is more common than anemia in pregnancy. It may progress and prove fatal. This woman has a profound anemia and looks very ill. Lactation may produce a very serious anemia.

There is great difficulty in making a diagnosis at the onset of an acute infectious fever. Malignant measles, smallpox, scarlet fever and cerebro-spinal fever may in the first stage present the same symptoms.

Dermatographia

W. W. Lashey. He has well marked dermatographia. There is first an area of anemia produced by a scratch mark on the skin. This is followed at the margins of the line by an area of hyperemia. There may be an exudation as well, and wheals appear. This is a factitious urticaria. We see this condition in neurasthenia and hysteria. It is usually associated with cold hands and feet. It is a stigma of a neurasthenic condition. This man says he is very nervous and has cold feet.

Scarlet Fever Undiagnosed

George Grienger (p. 80, 86). 26 years old; single; grocer. He complains of sore throat and a cold. Admitted January 3. He has been ill for two weeks and was delirious on admission. There is a family history of tuberculosis, particularly on his father's side. He has been healthy. He denies lues. He is temperate. He has not had rheumatism, typhoid or scarlet fever. There is no sickness in his household. He has had a cold and a sore throat since Christmas. There was a case of scarlet fever next door. He gave up work December 29 on account of pain in the head and back. He went to bed on

December 30. On December 31 was slightly delirious. A rash was first noticed on this day. On January 2 he was delirious and jumped out of a second story window, landing on the pavement. No bones were broken. On January 3 he was very maniacal; talking constantly. When seen by Dr. Frank Smith that day his temperature was 105°.

When admitted, his lips were covered with sordes and the tongue was cracked. He coughed a good deal. He had a diffuse rash. It was a mottled erythema, dusky, with distinct purpuric spots in places, especially in the groins and about the arms. There were no local symptoms or signs, i. e., the spleen was not palpable; no pneumonia; no tubercle bacilli in the sputum and no Widal's reaction. There is inequality of the pupils and a slight retraction of the head. The eruption looks like the macular rash of syphilis.

The disease that starts in like this is most often typhoid fever. The duration is against scarlet fever, against malignant scarlet fever rather. Those cases do not last more than 4 or 5 days when in this condition.

AMPHITHEATRE CLINIC

JANUARY 6, 1897 — DR. OSLER

Chlorosis

Kate Schultze (pp. 63, 71, 101). When admitted her hemoglobin was 30% and the red blood corpuscles stood at 40%. She has been treated with (1) good food, and (2) rest in bed. There has been a steady ascent in red blood corpuscles which now reach 90%. The hemoglobin has not gone above 40%. It is still a typical case of chlorosis. She has been treated for five weeks. Now iron will be given. In the Dispensary several cases have been cured recently by iron alone, without rest in bed or better food. This case shows that cure at times cannot be effected without the administration of iron.

Case XXI. Typhoid Fever—Fatal Case

Joseph Hering (p. 72). On Dec. 27th his temperature was high, 104° At 4 p.m. the pulse was 130. A bath was given. He did not take this well and was removed. He died the next morning. He was in the hospital 19 days. The autopsy showed cloudy swelling of the kidneys liver and heart. There were healing ulcers in the intestine. Pulmonary edema was present.

Case XXIII. Typhoid Fever. Death from Hemorrhage

Henry Lee, 28 years. Admitted December 28. He was taken ill three weeks before. On admission he was dull. The walls of the intestine were tense. Rose spots developed. The pulse was dicrotic. He vomited once. On December 31 he had a liquid stool that was blood-stained. This had no effect on his temperature. Later passed two bloody stools; the second one was 200 cc. of pure blood. This was followed by a drop in temperature. He seemed to die directly from the hemorrhage.

Amebic Abscess of Liver

Liver exhibited. The patient had a tumor in the flank, which was opened under cocaine. The abscess was not large. It was not bigger than an orange. It was in the right lobe and was well situated for operation. The operation would have been simple. It is interesting that the liver perforated externally. The abscess was situated above and to the right of the gall bladder.

This case was shown by Dr. Halsted at his clinic, December 11th. It was then thought to be an abscess in the back muscles.

Case IV. Pneumonia

Charles Schmidt. Illness began December 16, six days before admission. A chill came on after prolonged exertion. He had a sharp pain in the right side. He continued to work for four days out of doors, but felt very ill. He thinks he had much fever during those days. When admitted his mind was clear.

There was no cyanosis. The vocal fremitus was present on both sides. Flatness in the back below the fifth rib; in the lower back it was nearly absolute. Behind in the flat area there was tubular breathing. Sputum on the 22nd was very typical, being rusty and containing many cocci. Temperature on admission was 96.5°; due probably to cold and exposure. The crisis occurred on the 7th day. The temperature fell within 12 hours from 102° to normal and has remained normal. Interesting as a pneumonia of the right lower lobe. The physical signs were well marked. The temperature was normal within 24 hours after admission. Quite often we have these cases of pneumonia in which the patients enter the hospital on the last days of their illness. They have often been up and around and have had no medical treatment. The crisis occurs and recovery follows in many cases.

Case XXIV. Tphoid Fever. Death from Perforation

Norris, a colored man. This is the fourth fatal case we have had of typhoid fever. He was one out of 6 or 7 cases in the same family. One or two died at home; three were admitted to the hospital. He had well marked diarrhea, abnominal tenderness, a rapid pulse and a feeble heart. One day he complained of pain in the abdomen and distention followed. We were looking all along for signs of perforation. The abdomen became more and more distended. But the symptoms were never definite of perforation. At autopsy, a perforation was found in a coil of intestine in the pelvis. The peritonitis was diffuse over the intestines but chiefly involved the pelvic peritoneum. It was an unusually large perforation and was located in an ulcerated patch with very thin walls in the small intestine.

In this case, after the perforation, there was no fall in temperature. This is unusual. His temperature kept up to 105° nearly until death. On the 28th he had a collapse. There was sinking of the eyes and a pinched appearance of the face—Hippocratic facies. Before this he was very bright and rational.

Scarlet Fever. Undiagnosed

George Ginger (pp. 83, 94). This man was admitted in the condition of active delirium. He was maniacal. He had a bad family history as far as tuberculosis was concerned. He had not been well since before Christmas, as he had a cough and headache. He dates his illness from a week ago yesterday. He did not go to bed until the afternoon of the 30th. He was slightly delirious on the 31st, and his sister noticed a rash on his chest. On Friday, January 1, he was much worse and more delirious. On Saturday, he became maniacal and jumped from a second story window. He was violently delirious on Sunday when admitted; temperature 105° The tongue was dark, almost black; sordes were present on the lips. The pulse was 135. Over the body was a diffuse rash. The skin had a somewhat bluish look. There was a diffuse erythema with purpura over the trunk and arms giving a mottled appearance. Here and there over the arms and legs were localized spots looking like rose spots; and there were numerous petechiae about the knees, elbows and groin. The rash looked like a typhus rash. The feet had a diffuse bluish look. On Monday, the 4th, the rash looked like a faded erythema. The spleen edge was just palpable. The throat was negative. Nothing abnormal found in the lungs. They were examined with great care as pneumonia was suspected. There was no evidence of typhoid fever except the rose spots. No agglutination of typhoid bacilli in the Widal test. Yesterday he was very restless; muscular ataxia was pronounced. The temperature ranged from 100° to 105°. The autopsy showed a mottled parenchymatous degeneration of the heart and slight pericarditis, but no meningitis and no evidence of typhoid fever in the intestines. No diagnosis was made either clinically or anatomically.

(January 12. Yesterday a case of scarlet fever developed in the ward where he was first placed, and today one of the members of his family has come down with scarlet fever.)

Case V. Pneumonia

Rose Wrile, 3 years old (pp. 89, 96, 116). She came to the Dispensary on December 30 complaining of a cough which was worse at night; duration 2 days. She was admitted yesterday. The physical signs were doubtful then. She now looks perfectly comfortable. Her temperature this morning was 103.8°; pulse 148; now it is 136. The respirations have been up to between 80 and 84 today. They were 64 last evening. She exhibits little distress at present; in fact is quite placid. She coughs occasionally. The pulse volume is good. The lungs are clear in front. The intercostal spaces are not well seen behind on the right side and there is no respiratory movement seen here. The percussion note is a little Skodaic under the right scapular spine. There is flatness from the middle of scapula down. Over this flat area there is intense tubular breathing. A few râles are heard here during inspiration. Yesterday there was no actual consolidation. Now there is definite consolidation of the right lower lobe. The temperature is not very high. The prognosis is good because she is 3, just as it would be bad if she were 70. Infants rarely die of pneumonia; the aged rarely recover. She will have an ice jacket and 15 minims of aromatic spirits of ammonia and a little ipecac wine.

DISPENSARY CLINIC

JANUARY 7, 1897 — DR. OSLER

Four drachms of potassium chlorate are supposed to be a fatal dose but two drachms have killed a child. The symptoms are great uneasiness followed by anemia and cyanosis, diarrhea, dark brown urine and pain in the hypochondria. Ninety-five per cent of the potassium chlorate can be recovered from the urine and feces. Free dilution does much to diminish the poisonous effect of the drug, which acts most seriously on the kidneys and blood.

In 1825 Caleb Parry of Bath first described exophthalmic

goitre. Graves' article appeared in 1835 in the *London Medical and Surgical Journal.* Basedow published his description in 1840. Basedow noted the tremor in one case. This is usually though to be a much later discovery (Marie 1883).

Stomatitis

Edward Garopy (p. 75). He has entirely recovered. Another case of stomatitis was recently seen by Osler. In this also no medicine had been taken but there was extreme salivation. It looked like mercurial stomatitis.

Chlorosis

Matilda Buck, age 23 years. She complains of pain in the abdomen and shortness of breath. The family history is negative, except that a sister is pale. Menstruation is regular; not painful. Pain in the epigastric region for four or five weeks. No vomiting. No distress after eating. Hemoglobin 35%. Loud murmurs are present at the base of the heart. The spleen is not palpable. Examination of the abdomen is negative. She looks well nourished. With 35% hemoglobin the red blood corpuscles may be only slightly reduced in number. Osler reported a very severe case with swollen feet in which the hemoglobin was very low but the number of red blood corpuscles was nearly normal.

Case V. Pneumonia

Rose Wrile (p. 88, 96, 116). She rested well last night. Her temperature has not been above 102°. The dulness has extended to the top of the lung. There is tubular breathing accompanied by fine râles. The respirations are very rapid. She has little appetite. She is irritable. That is a good sign.

DISPENSARY CLINIC

JANUARY 9, 1897 — DR. OSLER

Scleroderma

Levi Baer, 44 years old. Farmer. He first came to the hospital last March with such hardening of the skin that it made him helpless. He cannot make a fist or stretch out his fingers. The position of his hands with the fingers partially flexed is peculiar. The terminal phalanges are flexed at right angles. The little finger is permanently hooked. The skin is a little rough over the knuckles, and there is a little ulceration over the knuckles and tips of the pads. The hands feel very hard. One cannot pick up the skin at all. They feel like frozen hands or hands in wax. There is no pain. The induration extends up the arms. It does not limit the movements of the elbow. The skin over the chest and shoulders is also hidebound. His face and forehead are smooth. His skin is indurated or sclerotic. The condition is scleroderma or hardening of the skin. The sclerosis is confined to the subcutaneous tissues. This is a case of scleroderma universalis. He is taking thyroid extract. He has taken it steadily since last March and thinks he is much improved, but as a matter of fact he is not a bit better. Another form of the disease is scleroderma circumscripta—the morphea of Addison.

Scleroderma is a tropho-neurosis of unknown origin occurring in the two forms just stated. The circumscribed areas occur in patches that look like marble. It is not settled that the two forms are the same disease. The prognosis is more hopeful in the circumscribed form. In this the sclerosis may wander up the arms for example, leaving areas unaffected. The scleroderma universalis is very chronic. It is most shocking when it attacks the face. The patient then becomes unable to shut his eyes or open his mouth. Complete immobility may result. It may be necessary to remove the teeth in order to feed him. Death is due to asthenia or intercurrent affections. This

man has necrotic lesions with resulting superficial ulcerations. Sclerodactylie is a related disorder in which the fingers become deformed and the skin thickened and sometimes pigmented. This may occur independent of scleroderma. In scleroderma there may be such extensive pigmentation of the skin that it may be mistaken for Addison's disease. It is a rare disease. Osler never saw a case until 4 years ago. Within a year he saw five cases; in one case, when the patient stood up, his legs became purple to the waist. The etiology of the disease is unknown. Owing to the extraordinary influence of thyroid extract on the skin in myxedema, it is used here. Lustgarten reports a case of cure. This man today insists he can do more than he could. The outlook in universal scleroderma is always bad. Spontaneous cure may result in the circumscribed form.

Erythema Nodosum

Elizabeth Freund, age 13, 3004 Elliott Street (see p. 93). In May, 1896, she had necrosis of a bone of the left foot following a frost-bite. This is unusual. She has had frequent sore throats. She has never had rheumatism. There is no history of rheumatism in her family. Ten days ago blotches the size of a pinhead were seen on the leg and she became restless at night. A large blotch appeared over the buttock; a few on the face. They were chiefly on the front of the leg. They are raised and infiltrated areas with red or purplish centers. There are five on the left leg; four or five on the right leg. They disappear on pressure. It is the exact picture of the other case (Mrs. Miller, pp. 43, 76). The heart sounds are clear. Her tonsils are swollen. The coagulation time of the blood is between 5 and 6 minutes. Rx. Calcium chloride, 20 grains three times a day.

The other patient with erythema nodosum is not well yet.

Erythema is perhaps more commonly seen in rheumatic families. But labeling it a rheumatic manifestation is begging the question. It was formerly thought that purpura associated with pains in the joints was rheumatic in nature, hence the term rheumatic purpura. The same is true of gonorrheal " rheumatism." Her tonsils are swollen.

Carcinoma of the Stomach

Jacob Younger, age 66 years. He complains of "stomach trouble." He has kept nothing on his stomach for a week. Much belching of wind. Loss of strength and weight. No pain. He has ringing in the ears. Family history: his brother died of stomach trouble. This man has had good digestion all his life. Some claim that in patients with carcinoma of the stomach the onset is preceded by years of indigestion.

He looks a little pale but is not a yellow tint. There is a marked arcus senilis. The abdomen is flat and below the level of the costal margin. The respiratory movements of the abdomen are normal. The skin is a little sallow. The wall is so thin that one can see the coils of intestine. There is a mass, which since beginning the examination of the abdomen has become smaller. It fills the left upper quadrant of the umbilical region. Observe the movements of the mass. They are: (1) well marked movement on deep inspiration. It descends at least two fingers' breadth; (2) pulsation, systolic in time, communicated from the abdominal aorta; (3) intrinsic movement. It has become distinctly smaller. Both intestine and stomach exhibit intrinsic movements. (4) mechanical. The weight of the tumor might carry it over when the patient turns on the side. Very slight movement here with change of position. It moves to the middle line but not beyond. Now palpate—always with the full hand. A mass is felt extending to the left almost to the costal margin. It does not extend to the costal margin in the left parasternal line. It is not hard, but varies a little in hardness during the examination. It descends a good deal in inspiration. Resonance is present over this tumor.

DISPENSARY CLINIC

JANUARY 12, 1897 — DR. OSLER

Dr. Osler last week saw a mouth breather 8 years of age. The chest was emphysematous and barrel-shaped. He had an attack of cyanosis and had had asthma.

Erythema Nodosum

Elizabeth Freud, age 13 years (p. 91). There are more spots and the legs are more swollen. She is not as well as when here before.

Callosities of the Feet

William Wrede, age 61, milkman. There is a callosity on the plantar surface of the right foot. He complains of coldness of the foot and also has cold hands. The pads of both feet are sore and callosities are present. A good deal of subcutaneous fat is present. There is an abrasion caused by the cutting away of tissue. *Local asphyxia* is fullness of veins with lividity. *Local syncope* is fullness with pallor. This is not a perforating ulcer. It is simply an abrasion in a callosity. The perforating ulcer is seen in two diseases: (a) locomotor ataxia and (b) diabetes. This man's health has been pretty good. He states that he always had a red face. He says he is not exactly temperate, but has not been a heavy drinker. He drinks half a pint of whiskey a day. On the lobe of the ear there may be found: (a) tophi, (b) milia (rather rare), (c) Darwinian tip or Woolner's tip.

Lateral Nystagmus

Harry Norris, 19 years old, tobacco presser. He complains of stiffness and soreness of the joints. In a young man with these symptoms always suspect gonorrhea. The discharge may disappear with the onset of the arthritis. This man has not had gonorrhea. He has had the stiffness for 14 weeks. His face shows acne and comedones. The rapid lateral movement of the eye balls (nystagmus) was first noticed when he was 4 years old. It is a clonic contraction. It is entirely a lateral nystagmus. The excursions become wider when he looks far to the side or up-and-down. It does not interfere with his sight at all, and he does not notice it himself. This is very unusual. Read up nystagmus in Gowers' textbook.

All acne sores come from comedones. It is Nature's way of getting rid of them. Treatment of acne: Steam the face or

soak it in hot water half an hour every evening. Then press out the comedones that are softened. Keep this up and in a week great improvement will be seen.

AMPHITHEATRE CLINIC

JANUARY 13, 1897 — DR. OSLER

Malignant Scarlet Fever

George Grienger (pp. 83, 87). He had a diffuse rash. Before death he had retraction of the head and inequality of the pupils. He was admitted on the fifth day of the disease in a delirious state. Several points have come up: (1) There had been a case of scarlet fever in the house before. We did not know that. (2) Another case has developed in his house. (3) A case has developed in the ward in which he was first placed. On the third or fourth day when Osler first saw him the rash was rather mottled. We see similar delirious cases in malignant measles. We do not have active maniacal symptoms at the onset of smallpox, but in pneumonia and typhoid fever they may occur.

Death occurred on the seventh day. Usually in hemorrhagic scarlet fever death takes place from the third to the fifth day. In cerebrospinal meningitis and cholera, death may occur in a few hours after the onset.

Death in Mitral Stenosis

Mabel, age 20 years. She said she had a "cataract" when ten. It was actually an interstitial keratitis. Two months ago she noticed swelling above the shoe tops. The past year she has had shortness of breath. She had frontal headache often when the eyelids were puffy. She had too high a color. There was a marked thrill at the cardiac apex. Relative dulness began at the upper border of the 3rd rib. A thrill, apparently presystolic in time was felt. There was a systolic murmur, and a marked echo was heard. The legs were markedly swollen. She had severe dyspnoea at times. At 4:15 p.m., January 6,

the patient was resting easily. She was heard to groan; became markedly cyanosed and died within two minutes.

She had scarlet fever when 9 years old. Was it asked whether she had arthritis with her scarlet fever? She had not. She had congenital syphilis producing infantilism. She did not look 20. She had an interstitial keratitis.

The time of the murmur in the cardiac cycle and the quality—vibrating, rough, interrupted, and echoing—are associated with trouble at the mitral orifice. You may hear a similar murmur of blubbering quality secondary to aortic insufficiency but this never terminates in the sharp snappy first sound.

The peculiarity of the death should be noted. Sudden death is rare in mitral stenosis, while sudden death is common in aortic insufficiency. In most cases of aortic insufficiency, death results from arterial sclerosis. She died from a globular embolus blocking the mitral orifice. It is very rare to have an embolus block the auriculo-vestricular orifices. Osler only saw one other case; that was in a child of 8. Death occurred while running from one room to another. The autopsy showed a sarcoma of the kidney with growth into the renal vein. A large block had plugged the pulmonary orifice and the tricuspid orifice was also plugged.

In mitral stenosis the right ventricle is greatly hypertrophied and also the left auricle. Some hold that the left auricle may be heard pulsating and may be situated in front in the region of second interspace. Osler has never seen this condition. A ball thrombus is the rarest of all cardiac thrombi. This was probably first attached to the auricular appendix. Note the rigidity of the mitral valve segment. The size is about the same in all these cases. It just admits the tip of Osler's little finger. Corrigan called it a "button hole" contraction. The muscular papillae are inserted right into the valve. The cordae tendinae and valve segments are chiefly affected. The muscular ring is not involved.

There were only 5 cases of ball thrombi on record when Osler

wrote his report in Volume II of the *Johns Hopkins Hospital Reports.*

Points to note in this case:

(1) No rheumatism. It does not play the important factor in mitral stenosis.*
(2) The occurrence of scarlet fever as a possible causative agent.
(3) The well-marked physical signs.
(4) The sudden death.
(5) The ball thrombus.

Case V. Pneumonia with Purulent Pleurisy. Death

Rosa Wrile, age 3 years (pp. 88, 89, 116). Admitted January 3 with cough and fever. The family history was good. Eleven days before admission she complained of feeling cold and feverish. Later she began to cough and had pain in the chest. She was put to bed two days before admission. Temperature on admission 104.8°; pulse 140; respiration 40. She was very fretful. The examination was negative except for slight dulness at the lower right base. Extensive leucocytosis—32,000. She was thought to have a pneumonia, centrally placed. The next morning there was dulness throughout the whole right base and tubular breathing. Her temperature fell on January 7 with the physical signs remaining the same. The crisis occurred that night. On the evening of the 8th the temperature rose, touching 103.1°. On the 9th dulness extended to the front, with diminished vocal fremitus and respiratory murmur. Tubular breathing was present.

The rise in temperature might be due to (a) a relapse or (b) complications—of which pleurisy and pericarditis are the more common.

The chest was tapped on January 10 and straw-colored fluid was withdrawn. It contained polymorphonuclear leucocytes,

* It is now held that "mitral disease is due in the large majority of cases to the rheumatic infection" (White) even in cases in which no history of rheumatic fever can be elicited.

many of which were ameboid, and cocci supposed to be pneumococci.

Yesterday the patient was seen by the class. The alae nasi dilated at each respiration. The right side of the chest bulged. There was complete absolute flatness on the right side, with pure tubular breathing and whispered bronchophony. Vocal fremitus was present. All the signs pointed to pneumonia but the bulging of the chest, the displacement of the heart, the history of the case, and a slight muffling of the tubular breathing indicated a pleural effusion.

Yesterday afternoon 250 cc. of fluid were removed. It was thicker than before, but not the green thick pus of empyema due to *micrococcus lanceolatus*. The cultures showed streptococci. The child seemed worse after tapping. Owing to this and the fact that it was a streptococcal infection, a wider opening was made and permanent drainage was established. She seems somewhat better this morning.

DISPENSARY CLINIC

JANUARY 14, 1897 — DR. OSLER

Tapeworms

A tape worm was shown. In certain districts of Europe fish harbors the larval form of the tapeworm (Bothriocephalus latus) which grows into the adult form when eaten by man. Taenia solium is the pork tapeworm. Taenia saginata or mediocanellata is the beef tapeworm. This is the common one in this country. Cysticercus is the larval form. It occurs in beef and pork. The cysticerci of taenia solium are more easily seen as white dots in the meat, than those of taenia saginata. The worms of taenia saginata may attain a length of 10 to 20 feet. They have a peculiar aromatic oder. The odor of round worms is different. It gave Sebastian hay fever when he worked upon them in preparing his monograph. In the ripe segments of a tapeworm the ovarian tubes can be seen filled with eggs. The larvae of the pork worm can develop in the muscles of man the

same as in the flesh of the hog. A patient admitted a year or two ago had a general infection with cysticerci. He had fever and was very stiff, so he was thought to have rheumatism. The cysticercus cellulosae of the pork tapeworm, even after it has become calcified, can be recognized by its hooklets. These are not present in the beef tapeworm. Cysticerci may develop in the eye or in the brain of man.

There is as much danger from veal as from anything else.

Aneurism of the Arch of the Aorta

Fred Buliver, age 44 (pp. 27, 59, 107, 114). His voice is quite suggestive in a man of his age who has worked hard. It leads one to look for trouble in the chest and not in the larynx. Our three aneurism patients all came with respiratory symptoms. There are: 1) aneurisms of physical signs and 2) aneurisms of symptoms. This man has a cough, shortness of breath, huskiness and pain. The pain is in the lower back. The physical signs are: 1) the difference of pulse in the two radials; 2) visible pulsation on the right side above the clavicle. This is much less than it was previously. When aneurism is suspected place the patient in a good light and good position. Here the whole sternum down to the 4th rib can be seen to move with each heart beat. There is deficient resonance over this area. There is now a very loud murmur over the aortic region, manubrium and sternal notch, and a soft murmur at the apex. No shock of the second sound can be felt. He has then pulsation and bruit without a tumor. His apex beat is in the normal position. Potassium iodide aids in the consolidation of the sac and relieves the pain, which is marked. He is taking 10 drops three times a day.

Incipient Pulmonary Tuberculosis?

Charles Brown, 18 years old. Salesman. He has a cough, slight expectoration, and pain in the left back and chest. The family history is good. There is a slight friction murmur on the left side. He awakes every morning with a cough. We

think more of this condition now than a few years ago as we know now that tnuberculosis often begins with a pleurisy, either dry or wet. These cases have to be examined with the greatest care. The examination of the sputum is sometimes worth more than the physical examination. He has a temperature of 100°. This is suspicious. In a few cases, especially those starting with pleurisy, one may find tubercle bacilli in the sputum before the physical signs develop.

DISPENSARY CLINIC

JANUARY 19, 1897 — DR. OSLER

Digestive Symptoms in Chlorosis, reported by John W. Coe. Senile Tuberculosis, reported by Miss Wolf. One should be cautious in giving morphine in advanced tuberculosis. One-third of a grain is a large amount. This man according to the history took 3 grains within 6 hours!

Dextrocardia

Edgar Randall. There is a pulsation in the 4th and 5th right interspaces in the front of the chest. This may be due to: (1) pleurisy pushing the heart over; (2) a chronic pleurisy drawing the heart over; (3) aneurism; (4) pulsating empyema. This is not an uncommon situation for a pulsating empyema. Upon palpating this pulsating area the shock of the heart's second sound is felt. There is no impulse on the left side in the cardiac region. Now percuss. On the right side vertical dulness starts at the top of the 4th rib and dulness extends horizontally from the mammillary line on the right to the parasternal line on the left side. The movements of both sides of the chest are equal; no bulging. The intercoastal spaces are marked on both sides.

This is a case of dextrocardia. As an anomaly it is very rare. Situs transversus lateralis is the lateral transposition of the viscera. Dextrocardia is usually associated with transposition of the other viscera. The liver dulness is here on the left side.

Stomach tympany is on the right side. This boy is also a monorchid.

Trichter Brust in a Mouth Breather

Roy Cox, 8 years old. This boy keeps his mouth open when awake and sleeps with it open. He makes a snorting noise which can be heard all over the house. There is a deep excavation of the sternum extending from the third rib to the ensiform cartilage where the deepest part of the pit is situated. The sides of the pit are formed by the costal cartilages of the 4th, 5th and 7th ribs. On the left side the costal cartilages make a very sharp angle, more than on the right side.

This is the funnel chest or Trichter Brust. It is not very common in mouth breathers. Both his tonsils are enlarged. The whole vault of the pharynx is filled with adenoids.

Splenic Tumors

1) All acute infections are associated with an acute splenic tumor.

2) Certain of the chronic infections, such as malaria, are associated with an enlarged spleen.

3) Certain blood diseases—as (a) leukemia, (b) Hodgkin's disease and (c) splenic anemia.

4) Congestions: (a) chronic passive in cardiac disease, (b) in cirrhosis from portal obstruction.

5) Tumors—Echinococcus.

6) Heredity—A familial enlargement.

The Enlarged Spleen of Chronic Malaria

She looks very pale. The tongue is clean. She has a baby three months (?) old. She had chills and fever four months ago. Tertian micro-organisms are present in the blood. The abdomen is unsymmetrical. A prominence occupies the left umbilical region and left flank. It lifts the skin and descends a little with inspiration. By palpation, it is readily moved about. It can be lifted forward with a hand at the back. The edge is

easily felt. There is a distinct notch in front of the left costal margin. We can be certain of the diagnosis here. The notch on the anterior surface is plainly felt. Of very few things beneath the skin of the abdomen can we be absolutely certain. This is one of them. It is the characteristic large spleen of chronic malaria. The weight of this would be about 3 or 4 pounds. In a case last year in a man from Jamaica, a great malarial country, an immense spleen filled the entire abdomen. It must have weighed 20 pounds. He had never had chills and fever.

AMPHITHEATRE CLINIC

JANUARY 20, 1897 — DR. OSLER

Pneumonia in typhoid. Donahue had his pneumonia at onset; Carpenter as a fatal termination.

Case XXV. Typhoid Fever with Pneumonia at Onset

Zeika (p. 139). Admitted Dec. 19 with plain in the chest. He had chilly feelings at onset with burning in the chest and colored expectoration (blood). He was admitted on the 8th day of the disease in a state of collapse.

The patient is pale and emaciated. There is diminished respiration at the right base. Sibilant and sonorous râles are heard at the end of inspiration. The spleen is not palpable. The patient has had the typhoid fever facies but no abdominal symptoms. In pneumotyphoid the symptoms of pneumonia are not frank, and the consolidations are often scattered. In this man the physical signs were those of pulmonary involvement. These cases set you off the track completely, as does also nephrotyphoid and pleurotyphoid and those in which the brain symptoms predominate.

Chlorosis

Katie Schultze (pp. 63, 71, 84). Diet, rest and fresh air did not do much for her. A certain number of cases do well on these simple hygienic measures, without giving iron. In this

they were a failure. The chart illustrates the essential feature of chlorosis which is absence of hemoglobin.

Cancer of the Stomach

Wesley Benner. Inspection should always precede palpation. He comes complaining of dyspepsia and loss of weight. He is thin. His skin is dry, yet his color is good. His abdomen is excavated in the upper umbilical region and in the epigastrium. There is distinct fulness in the lumbar region. First note whether respiratory movements are present or not. Then note the iliac grooves and lines on the flank. In the normal abdomen one sees only the movement of respiration and the throbbing of the abdominal aorta. In very thin abdomens the outlines of the stomach, liver and even the abdominal aorta with its bifurcation can be seen, as well as the movements of the stomach and large intestine.

Now in this man we can see a distinct swelling corresponding to the outline of the stomach. Waves can be seen, usually passing from left to right. As the waves pass, the organ hardens very materially. Changes in outline such as these are called "patterns of abdominal tumidity," and often give the diagnosis. The shape of the swelling here gives the diagnosis. The greater and lesser curvature of the stomach are seen. One can make the diagnosis *de viso*. The stomach in some cases can be so distended as to occupy the right iliac region and right flank or even fill the entire abdomen. The distention may be so great that the walls of the stomach become paralyzed and the waves of peristalsis disappear. In a normal stomach waves of peristalsis are rarely seen. The stomach, intestine and bladder can show waves of peristalsis, but Dr. Osler has never seen them in the bladder.

Relaxed Abdominal Wall Showing a Pattern of Abdominal Tumidity

This woman has borne 7 children. As a result in such cases the abdominal wall is always relaxed. Sometimes the recti muscles become separated. She has a swelling chiefly below

the umbilicus. Little vermicular movements can be seen. They are chiefly central and small. They represent the coils of the small intestine. This morning the large intestine showed distinctly. The movements are increased by slapping the belly with a wet towel. The shadow of this woman's liver can be seen. It is tilted down. The lower border is three fingers breadths below the costal margin. The liver is not enlarged but simply tilted forward and displaced downward. This is enteroptosis or Glenard's disease.

Tuberculous Peritonitis

Ada Jones, age 16 years. Admitted January 8. No tuberculous history. Three weeks ago she developed pain in the lumbar region with dyspepsia. She had nausea and vomiting. Note that the symptoms set in with a gastro-intestinal disorder. On admission the temperature was high. It was 104°. There was distention of the lower part of the abdomen, and dulness in the hypogastric and umbilical regions. These physical signs resembled those produced by an ovarian cyst. A vaginal examination by Dr. Cullen was negative. A friction rub was present on the right side of the chest. The fact that she had a sacculated peritonitis, and was a colored girl and that pleurisy was associated with the peritonitis led to the diagnosis of a tuberculous peritonitis. A sacculated exudation is more common in tuberculous peritonitis than in other forms of peritonitis.

Last Friday the peritoneal cavity was opened.

The above remarks were made by Dr. Osler. The patient was not shown in clinic.

Tuberculous Meningitis

Lillie Freeman, age 8 years. She was in a deep coma when admitted to the hospital. Her uncle had died of tuberculosis. She was a very bright girl at school. She injured her back by falling down stairs, but recovered. All cases of tuberculous meningitis have a history of a fall, also all cases of infantile paralysis. This has been true since the days of Mephibosheth.

During the Christmas season her disposition changed, and she fretted about trivial things. In addition to irritability, she had nausea and headache. During the last week she has been drowsy and more or less delirious. Moaning cries were uttered at frequent intervals. There was rigidity of the arms and legs. The right eye was held partly open. The pupils were dilated. Numerous râles were present over the lungs. A leucocytosis was present; the white cell count being 15,000 per cmm. This is worth noting. A leucocytosis is said to occur in tuberculous meningitis. It is interesting that this girl who has been in good health until the middle of December should have a generalized tuberculosis. At autopsy tubercles were found all over the intestine, liver and kidneys and in the uterus and tubes. The disease was probably primary in the tubes and uterus. The involvement of the meninges is usually secondary as is tuberculosis of the other serous membranes.

DISPENSARY CLINIC

JANUARY 21, 1897 — DR. OSLER

Sir Thomas Browne said tuberculous roots sprout early. This is not always true. A report on Senile Tuberculosis was read by Miss Wolf. The mortality in some of the asylums and penitentiaries is appalling; especially in this country in the Southern asylums, the Philadelphia Almshouse, etc.

Barriere, *Revue de Médecin*, Oct. 1895. It is the best article on senile tuberculosis.

Chorea Minor. Chronic Endocarditis

Bessie Morrison, age 10. She comes complaining of nervousness and twitching of the hands. It was first noticed last Monday. Her mother feared she was getting St. Vitus's dance and noticed she picked up things awkwardly. There is no twitching now. Always ask in regard to rheumatism in cases of chorea. She had " growing pains " three years ago but no his-

tory of acute articular rheumatism. She suffers from a sore throat. Throat examined. The tonsils are slightly enlarged. Adenoids are present. Endocarditis occurs more constantly in fatal cases of chorea than in any other disease.

She has a little bulging of the precordium. The left nipple is higher than the right. The apex beat is in the 4th and 5th interspaces inside the nipple line. The area of cardiac impulse is rather wide. There is no thrill. The shock of the heart sounds is not felt. At the nipple line there is a very soft systolic murmur. A little rumble in diastole is present in the 4th interspace inside the nipple line.

These are the findings in the erect posture. In the recumbent position there is a marked change. The systolic murmur under the apex is higher pitched and pipy. The presystolic rumble is short but much more marked. The second aortic sound is much more intensified. She has an endocarditis undoubtedly and a slight valvular lesion. This is no new thing. It is not a fresh endocarditis, as with a fresh endocarditis one would not get bulging of the precordium. That means enlargement of the heart. The apex beat is also somewhat displaced. This cardiac disease may have been caused by the scarlet fever which she had, or by the "growing pains," as we know very mild attacks of rheumatism may precede endocarditis.

Sydenham's chorea or chorea minor is an exaggeration of the "fidgets." The movements are non-purposive and quite irregular. They are never rhythmical. All grades of muscular activity occur. This is the mildest possible. At the other extreme the movements are so violent that it is necessary to put the patient on a soft mattress on the floor. Nothing is seen more severe than these cases. Although St. Vitus's dance is looked upon as trifling by the laity, it is not to be so regarded. The heart complications are serious. The cause of chorea is unknown. Some say it is (1) caused by the rheumatic poison. Others regard it as (2) an infectious disease. The endocarditis associated with it favors this view. Treatment. Give her Fowler's solution, 1 to 2 minims three times a day; increase the dose until she takes 10 minims three times a day. This

and six weeks generally effects a cure. Look up the toxic effects of arsenic in chorea. See Osler's monograph on chorea.

The bruit of a fresh endocarditis gives no indication of the cause. Fresh endocarditis is a symptomless condition in most cases. You have got to look for it. The little beads on the valves give no symptoms. The trouble is the valves grow wrong from that time. They become sclerotic. The edge of the valve becomes gradually thickened and puckered. At the age of twenty, she may have a valvular orifice like the one you saw a week ago yesterday at the clinic. It may be twenty or thirty years before she has trouble from it.

Malaria

Negro boy, age 15 years (?). This patient has chills and fever. He had them first last fall. His respiratory movements are normal. The general contour of the abdomen is symmetrical. The costal grooves, the iliac grooves and the lumbar lines are symmetrical. The spleen is enlarged and readily palpable.

DISPENSARY CLINIC

JANUARY 26, 1897 — DR. OSLER

A paper was read by Mr. Walter Cox on the Toxic Effect of Arsenic in Chorea. The symptoms and signs are: (1) paralysis; (2) pigmentation of the skin; (3) peripheral neuritis. A gait like that in locomotor ataxia may develop. This may occur without the cardinal symptoms of arsenical poisoning. Only in the large doses do we get the beautiful action of arsenic in chorea. But in some patients with an idiosyncrasy we get a peripheral neuritis which may be fatal. Vomiting, puffiness of the eyelids and face are the early symptoms. Dr. Fowler of York introduced his solution of arsenic in 1786. He was the original " Dr. Slop " of " Tristram Shandy." * Thomas Martin of Mygate first used arsenic in chorea. See Osler's monograph.

* According to the Encyclopedia Britannica "Slop" was a caricature of Dr. John Burton, a physician of York. J. H. P.

Aneurism of the Aorta

Frederick Buliver, 45 years (see pp. 27, 59, 98, 114). He has paralysis of the left vocal cord; the right is negative. The larynx is slightly swollen. He is much worse.

Varicella With Mastitis

Daisy Jolly, age 11 years. She had headache, " sick-stomach," slight fever and then a " breaking out." These are the common features of chickenpox. Few reach maturity without having had it. Many escape scarlet fever. Dr. Osler asked the students who have had scarlet fever to raise their hands. Fourteen of the twenty-one students present in the room have never had it.

The rash appeared the Friday after Christmas. Now only the scars can be seen. Last week she began to complain of swelling of the right breast. It was more swollen than now, and hard. Mastitis is very rare in children following an acute infectious disease. It is common at puberty in both boys and girls. The disease it is most often associated with is mumps. Chickenpox is a disease with a few complications. It may scar almost as badly as smallpox, but, remember, in smallpox the rash is on the face and arms and rare on the body. Sydenham pointed this out. In chicken-pox the rash is on the body but rarely on face and arms. The pox has the same appearance in all the various poxes but it runs its course through the various phases very rapidly in chickenpox and different stages may be seen at the same time.

Cretinism

Virchow noted the great broadening of the base of the head in cretins. The teething is irregular. (1) The abdomen is often pendulous; (2) stunting of growth (dwarfing); (3) changes in the intellectual development; (4) changes in the skin. These are the cardinal signs of cretinism.

DISPENSARY CLINIC

JANUARY 28, 1897 — DR. OSLER

Influenza

Mrs. Daniels, age 29 years. She has been here often for neurasthenia. She had throbbing of the aorta and other typical manifestations of neurasthenia. Her temperature was normal on admission January 13. It continued to be normal until the 20th. At 8:00 p. m. that evening it was still normal. A chill occurred at 12 midnight; temperature 102°; it rose at 4:00 a. m. to 105.5°. It fell to normal January 21 between 4:00 a. m. and 10:00 p. m. The entire duration of the chill was over 24 hours. After the chill, nothing developed. On January 22 the temperature was normal. On January 23 it rose to 102°. She felt miserable and began to cough. She had a second chill on January 24. It began at 10:00 p. m. and lasted until 6:00 a. m. on the 25th. The temperature was 104° at 10:00 p. m. and at 3:00 a. m. She had then two paroxysms preceded by chills with an intervening day of low temperature. It looked like a case of tertian malaria but the blood examination was negative. But influenza is about and she had the bacillus in her sputum. Influenza comes on with headaches, pains in the back and legs and a rapid rise in fever. Her maximum temperature was 105.5°. The fall was rapid. This is the first time that the influenza bacillus has been found here. There is often a little broncho-pneumonia and bronchitis in these cases. Read Grainger Stewart's paper, *British Medical Journal,* August 4, 1894.

A paper was read by Mr. James D. Madison on "Nystagmus without other Symptoms." This form is rare. It may be hereditary. Miner's nystagmus is common. A change of occupation usually effects a cure.

Acute Endocarditis

Any of the acute infections may be associated with endocarditis. Bacteria lodge on the valves and multiply. The vege-

tations together with the bacteria form the lesions in acute endocarditis. It may be of all degrees of severity. The symptoms may be nil or very severe. In chorea and rheumatic endocarditis there are often no symptoms. Remember in most acute infections acute endocarditis is obscure, as it is latent symptomatically. Often a soft murmur is heard near the affected valve, and the heart is apt to be irritable. Endocarditis may follow tonsillitis, measles, syphilis and tuberculosis. It is not serious at the time. Its gravity is due to the fact that sclerosis follows; the valve becomes hard and thickened. Sometimes warty endocarditis assumes a definite picture. The vegetations become larger and form large excrescences, 8 to 10 mm. in length, looking like cauliflowers. These are made up of micro-organisms, fibrin fibrils and valvular tissue. There is actual destruction of the valve tissue. Hence the term, ulcerative, necrotic or diphtheritic infective endocarditis. The loss of substance is usually associated with an outgrowth of tissue. The mitral valve is most often involved, then the aortic and, rarely, the tricuspid. Owing to the severity of the symptoms, cases are termed malignant. It is an acute septic disease. It may be due to gonococcus, pneumococcus, staphylococcus or streptococcus. The streptococcus is the most common causative agent. Usually the micro-organisms can be obtained from the blood. Malignant endocarditis usually develops on old diseased valves.

Mitral Stenosis. Vegetative Endocarditis

John Zeites, age 40. Admitted January 28. He was in a hospital before on two occasions, once in 1883 and again in 1889. No rheumatism. He has all the physical features of mitral stenosis: thrill, loud shock, a rough systolic murmur and a presystolic murmur. He is much worse this time. He has chills, fever and sweats. The fever is the intermittent type. This type is common in malignant endocarditis. It is a septic fever. Wilks called the disease " arterial pyemia." His elevation of temperature lasts over 12 hours. In a man with a mitral disease like this man, with these new symptoms, there

is no doubt as regards the diagnosis. This is probably vegetative rather than ulcerative, as there is no evidence of emboli anywhere. It is a septicemia and we have nothing to check the disease. It is claimed, however, that anti-streptococcus serum has been used with success in several cases. It will be tried in this case. 10 cc. were injected yesterday and will be repeated today.

DISPENSARY CLINIC

JANUARY 30, 1897 — DR. OSLER

Report on Milia read by William W. Ford.

Mitral and Aortic Disease and probably Adherent Pericardium

Joseph Versali, age 14. He came January 22 complaining of cough and shortness of breath. Last July he was here with malarial fever. He has been a mouth breather, and has a marked Harrison's groove. There is rheumatism in the family history. Last summer he had pain in his legs.

He is a little pale; pretty well nourished. There is a rapid pulse. It is small and regular; no increase in tension. The chest is disfigured. There is a wide and unusually large area of cardiac impulse from the third rib to the seventh interspace extending out to the axillary line, and over the lower sternum and epigastrium. There is bulging of the precordia. The right nipple is lower than the left. There is marked systolic retraction in the apex region. There is a pulsation in the sternal notch, and in the 10th and 11th interspaces in the back. The important things are: (1) the retraction at the apex region, (2) the higher left nipple and (3) the pulsation in the back. On palpation, there is a heavy forcible impulse. The most forcible apex beat is in the 6th space within the nipple line. Always, when palpating the heart, feel for the cardiac impulse, the heart sounds and abnormal phenomena such as thrills. One can feel the *shock* of the heart sounds, not the sounds. There is here a faint thrill systolic in time. The shock of the second sound can be felt above. The upper limit of cardiac dulness

is not fixed. *Auscultation.* At the apex beat there is a very loud systolic murmur propagated to the axilla and back, and a loud echoing rumbling murmur in diastole. Neither sound is audible at the apex. Both murmurs become feeble toward the sternum. Above the fourth rib the second sound becomes loud and accentuated. Up-and-down the sternum there is heard a to-and-fro murmur composed of a soft systolic and a loud diastolic. The pulmonary second sound is much louder than the aortic sound, especially so when the patient holds his breath. The murmurs are transmitted to the viscera of the neck. He has combined mitral and aortic disease (with adherent pericardium?).

Chronic Adhesive Pericarditis

Edward Miller, 13 years old. He has a loud systolic murmur and a very wide area of cardiac dulness. He came on March 13, 1896 aching all over, especially at night. He had had a cough for two years without expectoration. He coughed all night. The urine was high colored. He was sent into the hospital at that time. He came back January 19, 1897. He has had spells of shortness of breath and vomiting. He has been short of breath ever since he had whooping cough five year ago.

Inspection. Very diffuse cardiac impulse, as low as the eighth space in the anterior axillary line and extending to the posterior axillary line on the left and as high as the third interspace in the sternal line. There is a heaving impulse as far as the right sternal border in the fourth space. Measuring in an oblique direction from the sternum, the longest diameter is 20 cm. Pulsation of the vessels of the neck extends to the angel of the jaw.

Palpation. The shock of the heart sounds can be distinguished. There is a suspicion of a thrill at the outer border of the heart's pulsation. There is a wide area of absolute dulness extending from the anterior axillary line in the sixth space to a finger's breadth from the mammillary line in the fourth space. The line of dulness on full inspiration does not change; on very prolonged expiration it seemed to be a little higher. The

area of systolic retraction in the sixth space is outside the mammillary line.

DISPENSARY CLINIC

FEBRUARY 4, 1897 — DR. OSLER

A Report was read by Miss Katherine Porter on Mercurial Stomatitis. In this disease a blue line may develop on the gums as in lead poisoning. Two grains of calomel in three doses produced salivation in a child of eight. Ptyalism is produced by very small doses when the kidneys are diseased. A house physician here was salivated profoundly with ⅛ or 1/10 grain calomel tablets. Only six or so were taken.

Syphilis. Secondary Stage. Rash and Iritis

Ida S. 30 years old. Married. She complains of a "breaking out." She first noticed it last night. It is present over the face, chest and elsewhere. The blotches have run together on the chin. They are red and distinctly raised. On the chest they are discrete; some are brownish looking. The rash is not so well seen on the arms and legs. The left eye shows distinct injection. There is an opacity of the cornea that is marked. There is a small vessel running directly up from the margin. This is evidence of an old scleritis. There is a history of injury when a child. The opacity in front is due to a glaucoma. There is a turbidity of the iris, indicating a definite iritis. She has a slight fever. Temperature is 100.5°. She will be given mercury unguentum. Rub it in the inside of the thigh or on the inner surface of the arm. The cervical glands are distinctly palpable. Any rash, such as measles or chicken-pox, would cause enlargement of the glands. They will be more palpable tomorrow. No initial lesion found upon examination.

Syphilis. Rash

Women, 30 years old; Bohemian; married. She complains of a rash and headache. She has had a rash for fourteen days; a

headache for eight weeks. The headache is worse at night. No miscarriages. No rheumatism. Often these patients come complaining only of " rheumatism." There is a rash over the chest and arms. Discrete raised reddish areas are present varying in size from 2 or 3 to 5 mm. They are abundant on the arms. On the back they are larger and more discrete. They are distinct infiltrations. The tops are rough and dry, looking like beginning vesiculation. They disappear on pressure leaving a brownish stain. No sore throat. No spots on the tongue or cheek. No iritis. The husband denies venereal disease. If he never had it he will have it now. Do not take much stock in husbands' statements. They are usually at fault. The fewer questions asked the better. Avoid leading questions. A rash like this persisting for fourteen days is a syphilide. Women rarely complain of the primary lesion. It is latent and often very trivial. It may be high up in the vagina or on the neck of the uterus, and may never attract attention. We see twelve women in this stage for one who comes complaining of a primary sore. If they do not have the rash they may not come to notice until iritis or syphilis of the liver, or brain syphilis develops. Many physicians with justice like to see vigorous secondary symptoms as then the tertiary symptoms are apt to be milder. Iritis usually comes after the rash, not with it as in our first case. Under treatment with mercury the rash usually disappears in a week. For the iritis atrophine should be instilled into the eye to prevent adhesion of the iris to the lens or to the cornea.

RECITATION

JANUARY 6, 1897 — DR. OSLER

A Report was read on Scleroderma by Mr. J. H. Mason Knox.

Two out of seven cases Osler has seen here have died. Some die of inanition. Sclerema neonatorum is a different disease. A child is living, yet apparently modeled in wax or frozen. It is even more rare than scleroderma.

Cancer of the lung is very rare. We have had no case in the hospital.

Inspection of the Chest as an Aid in Diagnosis

The symptoms due to bronchial obstruction are cyanosis and dyspnea. Orthopnea is not common in pulmonary tuberculosis. Pleurisy may be manifested simply by shortness of breath with no pain; yet the physical examination shows an effusion to be present. In acute pleurisy or early in pneumonia one may see panting breath due to pain. Notice on inspection whether the interspaces are similar on both sides. Examine a patient sitting in front of a good light. Phthisical patients often have very long chests. The apex beat is apt to be in the fourth space instead of the fifth. The alar chest or winged scapulae occur in phthisis as Hippocrates noted. The chest of patients with adenoids has grooves at the sides of the sternum and Harrison's groove, which is a circular depression in the lateral region of the chest corresponding to the attachment of the diaphragm.

DISPENSARY CLINIC

FEBRUARY 9, 1897 — DR. OSLER

Aneurism of Transverse Arch

Frederick Buliver, 45 years (pp. 27, 59, 98, 107). *Symptoms*: (1) cough; (2) dyspnea; (3) hoarseness; (4) pain; (5) dysphagia. *Physical signs*: (1) diffuse area of pulsation in the sternal region; (2) pulsation in the suprasternal notch; (3) a diffuse impulse on both sides of the midline; (4) trachael tugging; (5) systolic murmur; (6) paralysis of the left vocal cord; (7) telangiectasis along the attachment of the diaphragm. Musser says this is always present in these cases.

You cannot exclude syphilis, but he has no history of syphilis. The aneurism probably is situated at the orifice of the left carotid and the left sub-clavian and involves the arch. Very likely the orifices of the arteries are contracted with fibrin.

Aneurism of The Aorta

Robert Clayton, 47 years old. Negro. He has been a hard drinker. He had syphilis when eighteen. *Symptoms*: (1) cough; (2) dyspnoea; (3) hoarseness; (4) pain. This last is a recent symptom and is felt in the back; (5) dysphagia.

Physical signs: (1) pulsation in the second left interspace; (2) trachael tugging; (3) paralysis of left recurrent laryngeal nerve; (4) a systolic murmur near the seventh dorsal spine. All these signs might be produced by an intrathoracic tumor. The etiological factors—age, alcohol, syphilis, and race point to aneurism and also the fact that he has gained fifteen pounds since entering the hospital. He had an operation on the sternum in front of the chest three years ago the nature of which is unknown. This is a point in favor of tumor. About a month ago he had inequality of the pupils. He does not show this now.

Aneurism of the Innominate Artery

Richard Lee, age 36 years (pp. 67, 69, 75, 150). His family history is negative except for rheumatism. Has been a heavy smoker and drinker. Had a primary sore ten years ago but no secondary symptoms.

Symptoms: (1) cough; (2) dyspnea; (3) hoarseness; (4) dysphagia; (5) vomiting. This last appeared during the past few days.

Signs: (1) a diffuse area of pulsation over the sternal region; (2) pulsation in the suprasternal notch; (3) a diffuse impulse on both sides of the neck; (4) trachael tugging; (5) pulsation in both carotids; (6) projection of right clavicle—not as great dislocation now as there was formerly; (7) cricoid pushed to right; (2) pressure signs in right lung; (9) paralysis of left vocal cord and perhaps the right.

Pressure signs in the lungs are the most interesting feature in this case. The swelling we first noted on the left side of the neck is not as marked now. It was probably the displaced thyroid.

Aneurism of the Transverse Arch of Aorta. Hypertrophy of the Breasts

R. P. Hamberger. Clerk. Family history negative. *Past history*: He had typhoid fever eight years ago. Last summer he had a feeling of pressure over the chest. He now has a cough. The pulse is slightly weaker in the left radius. The cough is dry, hoarse and wheezy. The vocal cords are not paralyzed. He has soreness over the upper part of the sternum. There is dulness over the manubrium. He has lost weight. The mammae are remarkably hypertrophied. They are not sore. Hypertrophy of the mammae may occur in early tuberculosis. He was jaundiced in September and October. His case is obscure.

All our cases of aneurism are of the transverse arch. Really those of the ascending aorta are more common.

AMPHITHEATRE CLINIC

FEBRUARY 10, 1897 — DR. OSLER

We have had six cases of pneumonia with one death. That resulted from the most serious complication of pneumonia, namely, streptococcus pyaemia. This occurred in the case of Rosa Wrile, who died of a general streptococcus infection. See pp. 88, 89, 96, 116.

Case VII. Pneumonia

Kerchew. Age 30. Steamboat engineer. The past history and habits were good. On Saturday, January 31, he had pains under the clavicle. On admission high fever but no respiratory disturbance; rate 32. Physical examination of the lungs was negative. There was a slight cough. On February 5, his temperature rose to 104.5°. The next day the sputum was rusty. There was consolidation in the lower back with râles. Since then the condition has improved.

There was a peculiarity in the mode of onset. From January 28 onward for three or four days he had indefinite pains. There

were fewer pains on January 30. Usually there is a sudden onset, often within a few hours, in pneumonia. The patient can often tell the exact hour of the chill and fever. Count here the onset of the disease from the time the fever developed, namely on January 30. So the crisis was on the eleventh day. The highest temperature was a little over 104°. The respirations once reached 40; the usual range in pneumonia is 26 to 36. The pulse averaged about 100. Once it reached 120. His defervescence has taken place by crisis. Last night the temperature was 101.6°. This morning at eight it was 99.7°. There was involvement only of the lower lobe of the left lung, and there was nothing urgent in his symptoms. The leucocytosis was extremely moderate. The breath sounds are feeble and tubular. Medium sized râles are present. He has a little icteroid tint and the conjunctivae are a little yellow.

This case did not require any medicine.

Case VIII. Pneumonia. Death

Mary Vomastik, age 59 years. On January 24 patient had a distinct chill. Before this she had complained only of weakness. She was ill for a week and then sat up for two days. On admission, temperature 97°. She had a slight cough. Tubular breathing and dulness were present over the right back. On February 4, dulness increased. The leucocytes were 50,000 on admission, falling to 30,000. The pulse improved under strychnine and salt solutions. Temperature increased to 106°. At noon February 9, the patient died of asthenia with quiet though jerky breathing. The temperature rose gradually from admission to 106° when she died. The upper right back was chiefly involved. She died within one year of the time, namely 60 years, when in this country, pneumonia is the natural mode of death. There was slight dulness also at the left base.

Case IX. Pneumonia. Death

Miss Mahoney, 25 years old. Private ward. Death on the eleventh day. There was total involvement of the right lung

and also of the base of the left lung. In addition there was a dry plastic pericarditis.

Acute Exophthalmic Goitre

Graves' disease is of course essentially a chronic affection, although in a large group of cases an acute form is occasionally seen, but it is very rare. It may develop abruptly without previous manifestations. More commonly acute symptoms develop in the course of the disease. The most acute case was reported by Dr. Lloyd of Philadelphia which occurred in a woman aged thirty-nine. Her friends noticed for some time that her eyes looked rather large. Then suddenly she was seized with rapid heart action and great throbbing of the arteries accompanied by intense vomiting and diarrhea. The thyroid gland was much enlarged and soft. Delirium developed. Death occurred on the third day in a state of profound asthenia. These acute cases, as I said, are very rare. I saw two cases in which acute symptoms developed and rapidly proved fatal. They develop mental symptoms of a maniacal character; death occurs in a week or ten days. We have had two cases here. One was admitted eight months ago. A woman of thirty-seven years from Charleston, South Carolina, entered the hospital April 15, 1895, complaining of nervousness. There was a history of nervous trouble in the family. One sister at thirty-six developed goitre with prominent eyes and nervousness. She died suddenly after a long walk. A niece also has goitre. This patient was well up to the present illness. She was married at nineteen, and had three children. Ten years ago a goitre was first noticed. It remained the same until the winter of 1894-95, when it increased a little. Palpitation began nine months ago. Onset occurred suddenly one night. The goitre and palpitation developed just before her last pregnancy. While pregnant she improved. During the winter '94-'95, she was much worse. Exophthalmos developed during the summer of 1894. There was much itching and burning of the skin. On admission her restlessness was extreme. There was flushing of the face which spread over the entire body when the bed clothes were raised.

The pulse was 120 on admission. It reached 140 the day following. As a rule the rate was 130. No fever. General condition seemed good. Three days after admission she became maniacal and was taken to the isolation ward. The heart action was extremely rapid. The rate ran above 150 by April 23. She lost rapidly in weight. General erythema of the body developed. She refused to take food. On April 27 the pulse rose to 160; then became even more rapid. It went above 200 on the twenty-ninth. She became progressively more feeble. She died on April 30. She was given cold packs, bromide and chloral but the treatment did no good. At her home she had been in good condition.

Exophthalmic Goitre. Death

Margaret Rothe, age 19 years. German. Admitted January 13, complaining of nervousness, swelling of the neck and rapid heart action. The past history was negative. She had not had chorea or rheumatism, but was never strong. She came to America four years ago. Menstruation was regular. She was not a nervous-looking girl; rather staid if not stolid. In March, 1896, she had a nervous attack; possibly some mental disturbance was associated with it. She became nervous and easily excited. In May she became more nervous. She went to bed and remained there until July 4. First noticed rapid action of the heart while in bed. In July she was better. She noticed then that her neck was enlarged. She perspired readily and was disturbed by the rapid heart action. In November her eyes became prominent. On December 31, she had a nervous attack and was very excited. She did not know what she was doing. She took to her bed and was there until the time of her admission. From May until now she had progressively lost in weight. On admission she was restless; her skin everywhere erythematous; the pulse rapid, regular. Eyes prominent and full, a slight rim of sclera was evident above the iris on each side. There was some retraction of the lid but it followed the finger down well. There was a lack of convergence of the two eyes. The forehead wrinkled as she looked up. Her neck

measured 36 cm. at the level of the thyroid. There was a thrill in the arteries of the thyroid and a loud bruit. The thrill could be felt and localized in the superior thyroid artery. The heart impulse was from the second to the fifth interspace. The apex was in the fifth space 8 cm. from the mid-sternal line. The abdomen was negative.

It was thought to be simply an exaggerated case of exophthalmic goitre. On January 6 she was not as well. That night she walked in her sleep. On the 20th she was more flushed; at times very dull and stupid. On Feb. 1 very apathetic and very restless. Feb. 2 she vomited twice; restless; getting out of bed. Feb. 6 much worse. It was difficult to get her to take nourishment. She was very excited. Her pulse was weak and slower. She was very agitated and completely unconscious. On Feb. 7 she seemed to be in a desperate condition. Abrasions appeared on the legs and elbows where she had rubbed herself. The pulse was feeble. The eyes were sunken. It was impossible to make her take food. For the first time she began to have a little fever 99° to 99.6°. She lost flesh with great rapidity. On the morning of the 7th given 800 cc. of salt solution. Pulse did not improve. Heart failed rapidly. She died at noon.

The autopsy revealed a very large thyroid. Note it is a parenchymatous organ. There is uniform enlargement of its three lobes. The thymus also is enlarged. There are no observable lesions in the brain or the ganglions of the sympathetic.

These cases bear out the view that the disease is a hyperthyroidism; the antithesis of myxodema. It is a chronic toxemia due to over production in the thyroid of its metabolic products. Anatomically it has been shown that there are changes in the thyroid gland. See Greenfield's paper in the *British Medical Journal*, Dec. 19, 1896, p. 1261. He says the earliest alteration is in the epithelium which changes from cubical to columnar. There is an active secretion and absorption of the colloid material. It corresponds to a gland in active evolution. Halsted has shown the same changes in a dog's thyroid when a portion of the gland is removed. Salt solution was injected in this case. At autopsy numerous subacute hemorrhages were

found under the mucosa. It is said that injection of salt solution will cause multiple small hemorrhages.

DISPENSARY CLINIC

FEBRUARY 11, 1897 — DR. OSLER

Angina Pectoris. Death

John Rammell, age 66 years (see p. 15). Since January 1 he has had 7 or 8 attacks; some severe. In all there was great apprehension. A week ago yesterday he had two attacks. Last Saturday his friends remarked how well he was looking and he said he felt very well. In the afternoon he became very nervous and apprehensive. He bade his friends goodbye. Pain came on. He went to bed, but had so much pain that he felt compelled to sit up. Died at 11 o'clock, as his daughter said, " on his feet."

He was a healthy-looking man; thickset and ruddy. This is often the case. He never had syphilis. Sometimes the pain starts in the abdomen. In a case Dr. Osler saw last week the patient thinks the trouble is in his belly. He is an enormous eater. The distension of the stomach presses the diaphragm up against the heart.

Arsenical Neuritis

Paralysis from absorption of arsenic through the skin may occur as from arsenical plasters. The paralysis begins in the fingers and toes. It usually affects the feet first, and is symmetrical. In the hospital a man was given a total of 1 ounce and 1 drachm of Fowler's solution for Hodgkin's Disease; death followed from arsenical poisoning.

Death from the use of Arsenic in Chorea

Child, age 7 years. Well and strong until the present illness. Chorea began last August. For treatment she was given

Fowler's solution, one drop three times a day. Improved, but showed puffiness of eyelids; medicine omitted for two weeks, then resumed as chorea still persisted. Dr. Gambril saw her on Oct. 1. She had then not taken the medicine for two weeks. Her eyelids were puffy. There was a general erythema and some desquammation. The legs were flexed and atrophied. She had a tingling of the feet. As the child sat up, foot drop was marked. Later, she had tingling of the fingers. On Oct. 2 she was in good condition; the pulse good; no fever. In the afternoon she became worse; the pulse was rapid and also the respiration. Oct. 23 the muscles of the trunk were so weak she could not sit up. Strychnine was given and galvanism applied; the pulse slowed and also the respiration. On Oct. 28 the diaphragm and muscles of deglution were paralyzed. Oct. 30 death occurred. She took Fowler's solution for six weeks; seven drops three times a day. The total was a little less than two ounces; 882 drops was the maximum amount she could have taken and she probably took less.

Chronic Parotitis

Samuel Levenson, 23 years old. He complains of swelling of the side of his face. It has lasted three weeks.

Inspection: He is well nourished; a little pale. There is a swelling in the right parotid region extending back to the mastoid process and down to the line of the thyroid cartilage. In front it reaches to the angle of the mouth. It lifts the lobe of the ear. There are no abrasions of the skin. The point of maximum swelling is in the region of the parotid gland. The overlying skin is a little reddened. The swelling is unilateral as there is no swelling on the other side. There is a little fulness under the right eye. Movement of the facial muscles is all right.

Palpation. The swelling is not painful to the touch. This absence of pain shows it is not an acute infection. It is a very hard immobile mass, limited accurately to the gland, extend-

ing upward to the zygoma. It is firm and brawny. There is some edematous swelling in the neighborhood. No enlargement of cervical lymph glands. He cannot open his mouth more than a centimeter. The gums look perfectly natural. No swelling of the orifice of Steno's duct. Mouth moist, not dry.

Mumps is an acute infectious disease of specific nature. There is mild fever. The duration is from a week to ten days. It sometimes gives rise to a chronic process.

Secondary acute parotitis occurs in (1) infectious diseases especially; there were 6 in our first 289 cases of typhoid fever; pneumonia; in types of septicemia often in typhoid when it is a septicemia. (2) Diseases of and operations on the abdominal organs; even slight operations on the uterus. The whole subject of this curious group of cases has been worked up by Stephen Paget. (3) In acute paralysis of the facial nerve. Gowers mentions it.

Chronic parotitis: (1) idiopathic; (2) secondary syphilis; (3) chronic Bright's disease. In secondary syphilis it may last for weeks or months. (4) In affections or blocking of the duct, swelling of the parotid gland may result.

Treatment here: Paquelin cautery and 10 grains of potassium iodide three times a day, on general principles, although he denies lues and gonorrhea. This is a very obscure case.

Aortic Insufficiency

Abram Hunt, waiter. His whole head throbs and also his neck. He has a remarkable water-hammer pulse in the right radial; the left can scarcely be felt. The whole chest pulsates. This is aortic insufficiency. Nothing else but extreme hemorrhage would give a pistol-shot pulse like this. One could make the diagnosis across the room. The color of his lips could almost give the diagnosis; they are very cyanotic.

DISPENSARY CLINIC

FEBRUARY 16, 1897 — DR. OSLER

Empyema

109 cases (*Traité de Médecin* 1893)
Streptococcus 44%
Diplococcus 25%
Streptococcus and Diphtheria bacillus 3%
Staphylococcus 2%
Tubercle bacilli (?) 25%

Twenty-four cases reported by Prudden in the *N. Y. Medical Journal*, June 24, 1893.

	Total Number of Cases	Fatal		
Streptococcus	8	5		
Diplococcus	10	2	mortality	20%
Putrid cases	4	4	"	100%
Staphylococcus	1			
Tubercle bacillus	1			

A report on Chlorosis Rubra was read by Miss Georgiana Sands. The red color is due to a vasomotor disorder. See Alfred Stengel on Chlorosis in the *Twentieth Century Practice*.

Ulcers of the Feet. Abrasions

John Kain, age 20 years. Printer. He complains of swollen feet, an ulcer on his foot, an eruption, and pain. He had this ulcer a year. He had an ulcer on the bottom of foot two years ago which healed. He has two ulcers now; skin abraded and reddened. One ulcer is behind the internal malleolus and one behind the external malleolus. On the leg there are red circumscribed spots which do not disappear on pressure; also brown stains of old eruptions. He has no pain in the joints. He has pain in the " stomach." He had pains before the spots appeared. The pain in the " stomach " is steady, not violent and

once lasted for two days. The abdomen seems natural. His face is pale. No blue line on the gums. He does not appear to have had any secondary symptoms. He had a bubo in right groin four years ago following gonorrhea. He never had a sore on his penis. Osler accepts Jonathan Hutchinson's statement that one never sees buboes except in lues.

Aphasia Following An Acute Infection. Recovery

Gracie, 3 years old. She was taken sick Dec. 16, 1895 and had a high fever for seven days. After that the fever ended. On Jan. 3 she ceased speaking. She did not speak again until Feb 26th. After the illness had lasted a week, she could not hold up her head. She was very limp. In the middle of January she began to use her neck a little. After Feb. 26 she could sit up half an hour a day. When she attempted to say "Ma" or "Pa" she would first tremble. Speaking seemed to be a great effort. As late as May 5 she could not walk. She could stand by a chair. She has been slowly improving since then. Never had retraction of her head. If she tries to run, she stumbles. She cannot walk well toward night as she seems to get weak.

This is a very strange case. She must have had an acute affection, probably a meningitis. Cases of idiopathic cerebro-spinal meningitis have recovered. Aphasia following typhoid fever and embolism and hemiplegia in children is often only transitory as the other side of the brain gets educated. Now when she speaks or tries to grasp anything she first trembles violently. The prognosis is good.

Tobacco Angina

Matthews (pp. 79, 173). He is no better. He tried the effect of cutting out tobacco for a month, then as the attacks of angina continued he resumed its use. Dr. Osler says write him that he is a fool. He took strychnine before. Now give him nitroglycerine.

Jaundice

Peterson, age 37 years. Sailor. He cannot retain anything on his stomach and he has pain on eating. Onset, ten days ago. There is constant pain in the epigastric region; worse after eating. He has been quite a heavy drinker, and drinks everything. He is well nourished. He is deeply jaundiced. One can often bring out light jaundice by pressing a glass slide against the lips. His conjunctivae and sclerae are much jaundiced.

Case X. Pneumonia with Jaundice

Lewis Dixon, age 45, colored (p. 127). He complains of pain in the right chest and congestion. Family history and past history are negative, except for a pleurisy. Moderate drinker. On Saturday, Feb 13, he felt so weak he stopped work. But for five days before that he had been feeling ill. On Saturday a cough began and has persisted since then. Sputum has been scanty and blood-stained. No history of a chill.

Dulness in the right back of chest and axilla extends forward to the anterior axillary line and back almost to the vertebral column. There is almost pure tubular breathing over this dull area. The disease had passed beyond the first stage when admitted as tubular breathing was already present and there were no soft râles. There was also hyper-resonance on the left side showing compensatory emphysema had taken place. Crisis began at 2 p.m. yesterday. Leucocytes on admission were 12,000; this morning 10,000. The sputum is becoming mucopurulent. Râles are now heard on the right side, showing the third stage is beginning. This morning his temperature was 99°, pulse 86, respiration 38. The movement of the two sides has been about equal. The second pulmonary sound is ragged; on admission it was sharply accentuated. There is a condition of jaundice here. The yellow color of the mucous membrane of the lips is brought out by pressing a slide against them.

AMPHITHEATRE CLINIC

FEBRUARY 24, 1897 — DR. OSLER

Case XIII. Pneumonia. Death

John Loftus, 48 years old. Admitted February 22. Family history negative. Past history negative. Present illness began February 12 with a chill. This was followed by a slight cough and pain in the side. He had difficulty in expectorating owing to the pain. He was cyanotic on admission; respirations 38; pulse 104. Prune juice expectoration. The patient's condition continued to grow worse. When admitted on the 12th day of the disease there was moderate leucocytosis and a low temperature. The left lower lobe was involved. Died February 23 on the 13th day. He was not delirious at all. Hence there was no toxic effects on the nervous system. He had been a heavy drinker. His heart was very weak. Death in this case was unexpected. Usually these fatal cases are delirious before death.

Case X. Pneumonia with Jaundice

Dixon (p. 126). He was shown last week. Since then his temperature has not been above normal; but twice subnormal falling to 96°. This man at onset had no chill and no severe pain. He had jaundice. This may be due to (1) a toxic state, or (2), a catarrhal jaundice, or (3) weakness of the right heart and enlargement of the liver.

Case XII. Pneumonia

Annie Purnell (p. 135). This is the third case of pneumonia in the same house within a month. She had pneumonia before only three weeks ago. On February 18 she complained of pain in the abdomen and under the right arm. No chill. Dyspnea since. On admission, respirations were 34. Vomited twice; no diarrhea. Pulse 128 to 140. On February 21, the right side moved less than the left. The right apex in front was involved.

This morning the temperature is only 100.5.° Children do not expectorate at all. One may not get a trace of sputum. Examine the urine to see if the chlorides are diminished. The crisis occurred on the 7th day of the disease.

House epidemics are not uncommon, especially in prisons and other institutions. One interesting epidemic was in Frankfort, Ky. The occurrence of pneumonia in epidemic form early led to the view that the disease was infectious.

This case might be tuberculosis. There is no way of telling during the first week of pneumonia. Then typhoid fever may set in with a pneumonia. We now have had 13 cases of pneumonia with 4 deaths. This is 31% and is higher than our average mortality of all cases of pneuomnia treated. Since the hospital was opened our average mortality has been 29%.

Acute Pneumonic Phthisis

Mistaken for Pneumonia. Tabulated as Pneumonia, Case XI

Alfred Hanson, 52 years old. Sailor. No history of tuberculosis. Never a hard drinker. On Feb 2 had a slight cold. While in bed on the 4th he was seized with a chill. He dates his illness from that day. On admission he had flushed cheeks and herpes. He was thought to have a pneumonia of the left side. There was a friction rub and defective resonance. Over the right front was tubular breathing and flatness at the apex and behind. Rusty sputum. Leucocytes 15,000. The highest temperature was only 102.5°. The diagnosis of pneumonia was based on the physical signs and the sudden onset. On the 10th day of illness, the temperature fell. It was thought to be the crisis but the next day it rose again. That was Feb. 15. The day following tubercle bacilli were found in his sputum. Since entrance he has lost weight rapidly; 7 lbs. in all. His temperature has been irregular. He looks very ill. There is deficient resonance at the top of the right lung and tubular breathing. The percussion note is clear in the right back near the vertebrae.

It is an acute pneumonic phthisis. The patient may be apparently in perfect health when suddenly seized with pain

in the side. He had been well for years, with nothing suggestive in his history. Tubercle bacilli were found on the 12th day. This is very early. See Fränkel's article in the *Zeitschrift für klinische Medicin* 1894.

These were the cases Niemeyer would have said were simple pneumonia that tubercularized. The rapid onset, the simulation of croupous pneumonia, the tubular breathing, the rusty sputum, all go together to give the picture of pneumonia.

This man is improving. In many the process is rapid; toxic symptoms become manifest and they go in two weeks or a month. In some there is a uniform consolidation which undergoes rapid caseation, and *exitus lethalis* occurs in three months or so. The lungs on section look like Roquefort cheese.

This is not an uncommon type of pulmonary tuberculosis.

DISPENSARY CLINIC

FEBRUARY 25, 1897 — DR. OSLER

A report by Mr. Patrick J. Cassidy on Enlargement of the Left Ventricle in Aneurism.

In 82 cases of aneurism the heart valves were involved in 41. Of these 35 showed dilatation and hypertrophy of the left ventricle. Of the other 41 only 9 showed enlargement of the left ventricle.

Rheumatic Fever

Frank Oteenstek, age 19 years. Meat chopper. Complains of general pain. He has been ill for three weeks with pain in the joints, dyspnea, edema of the ankles, and loss of flesh. His temperature is now 100°. Family history. Ask in regard to rheumatism. One sister had rheumatism. This is his first attack. He gave up work three weeks ago. He was in bed the first week. Always ask in rheumatic cases if the patient was in bed. He did not have a high fever and there was not much sweating. The sweats of rheumatism are drenching. Only in septic cases, such as tuberculosis, pyemia, and ulcerative endocarditis, are they exceeded. The left knee, the foot and

ankle, the right knee, the back and right hand are now involved, and there is pain in the carpus and right shoulder. He cannot lift his right arm well. This is the subacute form of rheumatism. Now determine if we can exclude gonorrhea. He denies gonorrhea and also lues. Gonorrheal arthritis should be treated by surgeons. Always examine to see if there is an urethral discharge. Take no person's statement.

In rheumatism the danger is always remote. Dr. Osler never had a patient die from acute rheumatism or from intercurrent endocarditis.

Chronic Malaria

Frederick Wich, age 10 years (p. 175). Complains of chills. His mother and five brothers have chills. He was treated here last April for malaria with good results. Two weeks ago he had chills. First every other day, but for the last four days they have occurred every day. He has the facies and bronzing of advanced malarial cachexia. His spleen is a little enlarged and very hard. Blood count: 4,000,000 red corpuscles. Dr. Osler thinks this is too high. Hemoglobin 53%.

This patient was later thought to have Addison's disease in addition to the chronic malaria.

Purpura Arthritica

Heinburgh, age 39 years. Electrician. He has purpura over the legs nearly to the thighs. He feels well except for pain in his legs. The onset began about six weeks ago. He has pain in his knees. Purpuric spots are very thickly situated over the feet, forming a uniform dusky infiltration below the external malleoli. On the legs they look like large red freckles. This would be called purpura arthritica as he has so much pain in his joints. It is apt to appear in debilitated persons. This man has pulmonary tuberculosis. Give him Fowler's solution and Blaud's pills.

DISPENSARY CLINIC

MARCH 2, 1897 — DR. OSLER

Catarrhal Jaundice

William Councilman, 22 years old. Meat cutter. Complains of yellowness of the skin and slight anorexia. Duration, two weeks. If he had not had a yellow skin would have thought nothing about it. He did not notice it until someone told him he was yellow. Past history. He had dropsy and scarlet fever eleven years ago. "Tripper" two years ago, and probably a chancroid as there is no history of sore throat or of his hair falling out. He has drunk considerably. Ask now in regard to digestive symptoms. He says he had vomiting soon after the jaundice appeared.

Inspection. The patient is deeply jaundiced. He is well nourished. The sclera is yellow and so is the frenum of the tongue. You do not often get a very slow pulse in catarrhal jaundice and would not expect it in this case of only two weeks' duration. However, there is a slow pulse here. The temperature is normal. We expect this in catarrhal jaundice. His color is golden. It suggests a recent jaundice. The color of the skin seen in cases of long duration is actually bronzed. The chest and abdomen are symmetrical. Respiratory movements are normal. His entire abdomen moves in respiration. Note first the general contour, whether the abdomen is flat or prominent. Always look at the costal and iliac grooves. It is important to note the abdomen with special care in this case, as the gall bladder in thin persons may be visible. *Palpation.* The liver is considerably enlarged. This might be due to: (a) simple obstruction; (b) hypertrophic cirrhosis; or (c) neoplasm. Upon palpation, the lower border of the liver on deep inspiration is 4 or 5 cm. below the costal margin in the mammillary line. In expiration, the liver falls back almost under the ribs. The recti muscles are held so tense that the liver border is not palpable. The spleen is distinctly palpable. This enlarge-

ment of the spleen is a sign of hypertrophic cirrhosis. There is no history of malaria or recent acute disease which imght cause an enlarged spleen. Ask in regard to his stools. In jaundice, they are clay colored; in cirrhosis, they are not clay colored. He has not observed the color of his stools. His urine is dark. So, taking his age into consideration, the diagnosis is doubtless catarrhal jaundice.

Treatment. Start with a purgative. Cut out fatty foods; give a light diet without much meat. Give a great deal of water and as a laxative Carlsbad salts.

Late Secondary Eruptions in Syphilis

A patient from Ward F. is shown. There is an eruption over the chest, abdomen and arms. Some of the lesions on the arm have a scaly appearance. They are more marked on the inner side of the forearm than on the outer. There is none on the palms of the hands or the soles of the feet. The initial lesion on the glans penis is well marked. The lymph glands are enlarged,—the epitrochlears, cervical and iliac glands. It looks like a case of about six weeks' duration but is really of fourteen months. Finger says relapses are apt to occur at the sixth, ninth and fourteen months.

Cancer of the Stomach

George Erb. There is a movable mass in the abdomen.

1. It moves with respiration, descending from the level of the tip of the tenth costal cartilage to the level of the navel.

2. It has a distinct pulsation, synchronous with the abdominal aorta and the heart beat.

3. No visible intrinsic movements are made out on first inspection.

4. When the patient lies on the left side, the mass moves over a little to the left. When he lies on the right side, it is not felt at all.

The patient was then given bicarbonate of soda followed by tartaric acid. When the stomach became inflated, rhythmic peristaltic movements were plainly seen.

The man has an organic stricture at the pylorus probably scirrhus, although there is a chance it may be simple hypertrophy, and secondarily dilatation of the stomach. These patients are always thin due to: (1) fermentation in the stomach. It becomes a regular beer vat, and (2) constant secretion into the stomach with little absorption.

He has improved since admission as his stomach has been washed out repeatedly. A gastroenterostomy would benefit him and prolong his life. It might increase his weight 50 lbs.

AMPHITHEATRE CLINIC

March 3, 1897 — Dr. Osler

Case XIV. Pneumonia

Frances Schaeffer, 8 years old. Bohemian. On Feb. 21 she had chills followed by cough and headache. On admission, Feb. 24th, she was restless and looked feverish and ill. There was impairment of resonance over the whole right lower lobe. Pure tubular breathing was present over the scapula posteriorly. Crackling rales were heard over both bases. The temperature was 104° to 105° on the 24th. On the seventh day of disease, the temperature fell. The lower lobe of the right lung cleared up rapidly and now there is no tubular modification of the breathing. The crisis occurred on the 27th. The leucocytosis was 24,000.

This is a perfectly simple case with defervescence on the 7th day. She was more delirious than is usual in children of her age. She is now well. Expansion of her chest is good. There is still some dullness now at the right base. It is not often cleared up by the 6th day. A few crackling râles are now heard. The treatment consisted of an ice bag over her side, good food and nursiing. In addition, she was given strychnine and aromatic spirits of ammonia. We sometimes see 100

cases in children under ten years of age without a death. Rosa Wrile (pp. 88, 89, 96) had a streptococcus pleurisy; which is the most serious complication in pneumonia and she died of a general streptococcal infection.

Case XV. Pneumonia

O. M. Day. 17 years old (p. 153). Admitted Feb. 26 with pain in the left side, cough and shortness of breath. The family history is negative. *Past history.* Pneumonia on the left side when six or seven. Mumps, measles, scarlet fever, diphtheria and rheumatism. Present illness dates from Feb. 18 when cough developed. He had no pain in the chest. On the 19th the cough was worse. He worked on the 18th and 19th; so was not very ill. On the 20th, he had chilly feelings and the cough was worse. He worked until noon, when he went to bed. He worked on the 22nd until 11 a. m.; then he had a shaking chill. There was no shortness of breath, no pain, no bloody expectoration until the following day, the 23rd. It is interesting because an unusual history.

On admission the temperature was 103°, respirations 60 and pulse 116. Leucocytes 13,000. He had on examination flatness over the right lower lobe and the left lower lobe. Pure tubular breathing was present over the flat area in the right lower lobe. There was no expectoration. The temperature that day was not very high. It ranged from 100° to 102.5°. The following day he was much worse. He became cyanotic. The dullness extended to the right axilla. The temperature rose on the 27th to 104° and 105°; pulse 120 to 130; respiration 48 to 60. On Feb. 28th the temperature touched 105°. His face was flushed and he looked a little cyanotic. There was the characteristic grunting expiration. This expiratory grunt is pathognomonic and gave Dr. Osler the diagnosis as he sat at the microscope table in the ward. On March 1 the temperature fell from 103.5° at midnight to 100° at midnight March 2. Yesterday the temperature was low, 99° to 100°. He has expectorated only once. This morning the temperature touched nor-

mal. His condition is now comfortable. If we date the onset from the chill, his temperature reached normal on the 9th day of the disease. His defervescence has been by lysis. The leucocytes rose on the 28th to 35,000; now they are 14,000. He is not yet in the perfectly comfortable condition we see in patients after the crisis. His respirations are still 36; the pulse is 110, small in volume and drops a beat occasionally. He has a great deal of cough. There is still dullness over a wide area on the right side. It may have been a pseudocrisis but that is usually associated with a sharper drop in temperature. Remember with his drop in temperature the concomitant good symptoms have not appeared. He will do well. Give him strychnine and aromatic spirits of ammonia, also 3 ounces of whiskey in twenty-four hours.

Pneumonia is a disease with less serious complications than typhoid fever and the convalescence is more satisfactory.

Case XII. Pneumonia

Annie Purnell (p. 127). She is quite well. She had a pseudocrisis. There was not complete defervescence until the tenth day. The lungs are now clear. The right apex was involved. This was a mild case. We have to be careful in making our diagnosis of apex pneumonia in children owing to the possibility that it may be tuberculosis.

Acute Pneumonic Phthisis

Alfred Hanson (p. 128). Here is an interesting point. He worked in the steerage and so was constantly exposed to infection with tubercle bacilli. We never suspected in this case that it was anything but a simple pneumonia until the sputum revealed tubercle bacilli. The temperature since Feb. 24th has been very irregular. It touched normal on the 27th, sub-normal on the 28th and part of March 1st. The highest temperature was 103.5° (not a very high fever) pulse 108 to 120; the respiration was not very rapid; not above 32. His pulse today is full and just 100. It is easily compressed. There is no respira-

tory distress. He is in better condition than last week. He says he feels "first rate." There is an extension of the process behind with loud tubular breathing in the interscapular region.

We have three groups of cases of acute pulmonary phthisis. The *first* run a rapid course. There is rapid consolidation and rapid caseation. Death in three weeks is the earliest Dr. Osler has seen. The patient may die before you have corrected your diagnosis from pneumonia to phthisis. Patients usually die in from six weeks to three months. In the *second* group after infiltration has involved an entire lobe or the entire lung, the symptoms abate. Death occurs in four to six months. Section shows the lung converted into a dry cheesy mass with a ragged cavity at the apex. The *third* group begins acutely. There is rusty sputum and it looks like a very severe case but it passes on and becomes chronic. Cases in this group may live for years. Little has been written about this type in English. Waters of Liverpool has a paper. The subsequent course of these cases is that of chronic tuberculosis.

DISPENSARY CLINIC

MARCH 6, 1897 — DR. OSLER

Multiple Neuritis Following Typhoid Fever

Henry Fink. Age 10? He had combined paralysis of both extremities. He was completely paralyzed following his typhoid fever. His case is described in Volume V. of the *Johns Hopkins Hospital Reports*. His gait is now peculiar. It is due to bilateral footdrop. He lifts his heels very high so as to get his toes off the ground. He had typhoid fever two years ago. His hands show complete absence of the former paralysis.

Hodgkin's Disease

Charles Stewart, 25 years old (p. 137). The inguinal glands in Scarpa's space are enormously enlarged. Above Poupart's ligament they are only slightly swollen. The mesenteric or abdominal lymph glands are not palpable; neither is the spleen.

The axillary lymph glands are only slightly enlarged. They feel as large as cherries. The epitrochlears are enormously swollen. The glands in the cervical triangle are not enlarged. At the angle of the jaw in the maxillary triangle, the glands are large and shotty as are also those behind the ears.

One can get general enlargement of the lymph glands (adenopathy) in syphilis, carcinoma, plague, tuberculosis in children and adults, Hodgkin's disease and lymphatic leukemia. By its distribution in this case we think of Hodgkin's disease. The great enlargement of the inguinal glands points to this. The glands did not pain him. He came to the hospital for chronic bronchitis. It may be tuberculosis. The duration of the bronchitis points to this. He has had it for two months. His blood is normal, so it is not leukemia. His sputum is to be examined. We think on the whole of Hodgkin's disease as the most probable diagnosis.

DISPENSARY CLINIC

MARCH 9, 1897 — DR. OSLER

Hodgkin's Disease

Charles Stewart (p. 136). He had two sisters who died of tuberculosis. His blood count showed only 1000 to 1400 leucocytes. One gland was removed this morning. The probable diagnosis was Hodgkin's disease. It is a natural looking gland. It presents no sign of tuberculosis.

Phthisis Renum. Autopsy Specimen

This specimen is one of phthisis renum. It is usually a primary, rarely a secondary, tuberculosis. It may be an exception to Louis' law that " if there is tuberculosis in the body the lungs are affected." Here we have a normal left kidney. The right is transformed into a series of saccular dilatations. There is cheesy tuberculosis everywhere with necrosis. Also there is infection with other micro-organisms. One never gets this stink with tubercle bacilli alone. The upper end of the kidney is

adherent to the diaphragm. The ureter is enormously thickened and diseased. There is a profound tuberculous pyelitis. The infiltration extends into the musculature of the ureter. The other ureter seems normal. The prostate is sure to be tuberculous. The disease in the bladder looks fresher than that in the kidney. These are the cases the surgeon deals with and often successfully. See the *Boston Medical & Surgical Journal* of last week. Kelly, Holmes and Burrage have removed the kidney and ureter.

In this case there is pyelonephritis with extension of disease to the lungs and intestines. The second possibility in these cases of tuberculosis of the kidney is the occlusion of the ureter with large caseous masses, so a big pus kidney, a pyonephrosis develops. This is often mistaken for an ovarian tumor. A pyonephrosis is a common condition. It results not only from tuberculosis of the kidney but even more commonly from renal stones. There is a third possibility. Nature may cure the case. The kidney becomes blocked. It becomes sacculated and the contents become inspissated, and cysts form full of putty-like material into which lime salts may infiltrate.

In the lungs of this case there is a tuberculous bronchopneumonia and numerous tubercles. The disease in one lung is quite acute. The other lung is in better condition, but it contains miliary tubercles. The liver probably contains small tubercles; in fact it always does in these cases.

Aortic Incompetency—Autopsy Specimen

John Hofstetter, age 19 years. Florist. He complained of shortness of breath and palpitation of the heart. He was admitted Feb 12. Last November he had rheumatism of the shoulders, elbows, ankles and soft parts of the legs. He never had scarlet fever. Swelling of the legs developed and increased. He had vomiting and vertigo. When admitted he presented an all around broken compensation.

Examination of the heart obtained at autopsy. The aortic valve is puckered, folded and thickened. There are no fresh

vegetations. It is a chronic endocarditis (sclerotic endocarditis). The mitral valve is thickened but not especially sclerosed. The posterior segment of this valve is rather more thickened than the anterior. The mitral orifice is enlarged and dilated. The left ventricle is enormously dilated and hypertrophied. The aorta is very small. The right ventricle is dilated.

He died a little after 7 a. m. on Sunday. At 7 he was in fair condition. At 7.01 he gave a yell; his face turned purple; no radial pulse could be felt. He eyes were "all pupils," the nurse said. At 7.10 he was dead.

There are several points of interest:

(1) His attack of rheumatism was of recent date—last November.

(2) It is unusual to have the aortic valves involved in rheumatic endocarditis without the mitral.

(3) His rheumatism was very mild. The mild cases often produce the worst heart lesions.

(4) He was thought to have mitral insufficiency from the physical signs, but little trouble was found in the mitral valve at the postmortem examination.

We are skeptical now of a blowing murmur over the apex in aortic insufficiency. He had a wide area of cardiac impulse. There was a systolic retraction in one interspace behind. This is Broadbent's sign of adherent pericarditis. Osler thought he had pericarditis with adhesions. He had a marked diastolic shock and the other signs of aortic insufficiency. The autopsy showed no pericarditis.

AMPHITHEATRE CLINIC

March 10, 1897 — Dr. Osler

Case XXV. Phlebitis following Typhoid Fever

Zeika (p. 101). He came in with typhoid fever on Saturday, Dec. 19th and was discharged well Feb 15th. On Jan. 14th, after his temperature had been normal for 5 or 6 days, his left

foot looked more cyanotic. He always looked cold. There was slight edema around the malleoli, and the patient flinched on pressure there. The left calf looked larger than the right. The internal saphenous vein was felt throughout its whole length on both sides. On the 16th day of January the pain in the left leg was better but the leg felt cold. On the 25th he still complained of a cold feeling in the leg. He returned March 6 with swelling of the left leg and pain in the left knee. On Jan. 17 the leg began to swell and has remained swollen. The whole leg from groin to angle is swollen, cyanotic and edematous. The saphenous vein could not be outlined. There is tenderness over the calf; none in Scarpa's triangle. The circumference of the left calf is 33 cm. while the right is 31.75 cm. He had a good deal of pain. He always looked and felt cold and looked blue. Now he is fat and well. There is very little edema now. There is a little tenderness over Scarpa's space but no cord of the vein can be felt.

This is phlebitis which probably started in the popliteal vein. It has not involved the femoral.

End results in thrombophlebitis. Possibilities: (1) The thrombus in the vein may suppurate. This is the worst result as death from pyemia usually follows. This outcome is rare. (2) It may persist. If it does the leg remains swollen despite all you can do. It goes on for years. This man will go out better in a month or so and in two or three months will probably come back. Give a guarded prognosis regarding complete cure. You remember when Prof. Edwin Klebs visited the clinic, he pointed to his leg which had been swollen ever since he had typhoid fever many years before. (A student remarked that we had not seen him.) You are right, it was last year's class that saw Prof. Klebs. Never mind. Tell the story often enough and you will finally believe you saw him. I only know of one fatal case from suppuration occurring in this sequela of typhoid fever. A persistently swollen leg may also follow the phlegmasia alba dolens of pregnancy. (3) Cure. The patient becomes entirely well.

You may get arteritis, although rare, after typhoid fever. It is always followed by gangrene.

Liver Complications in Typhoid Fever

Suppurative processes about the liver are very rare in typhoid fever. You may have jaundice in typhoid but it is excessively rare and is usually catarrhal and slight. One form of grave significance is seen in malignant typhoid fever. In severe measles and scarlet fever as well as in typhus and yellow fever jaundice occurs.

The common lesion in the liver in typhoid fever are the lymphoid focal nodules. They may produce no symptoms. It is a question whether or not they lead to cirrhosis. In the bile passages the typhoid bacilli thrive. They were found here in seven out of fourteen autopsies. They had done no harm in these cases, but in some they lead to cholecystitis or gall stone formation.

We have had two cases of intense suppurative cholecystitis following typhoid fever. An operation was performed in both cases. One died. The gall bladder was found perforated in both.

Case XXVIII. Cholecystitis following Typhoid Fever

John Lehmnell, age 25 years. He had typhoid fever in October, November and December of 1895. It was a severe attack. Admitted here Sept. 1, 1896 with slight fever which lasted only 7 or 8 days. He returned again March 5. He was well until March 3. That day he had a shaking chill followed by fever and sweating. He gave up work the next day owing to fever and pain in his side. On admission the temperature was 104°, rising to 105.5° by midnight. It then fell gradually; yesterday it reached normal. There is much tenderness over the liver and gall-bladder. He still winces on deep pressure in this region. The abdominal wall is held tense. Jaundice appeared and bile was found in his urine yesterday. We are probably dealing with an acute cholecystitis caused by the typhoid bacillus. It is acute cholangitis at any rate. It is not too long after

his typhoid fever for us not to regard it as a sequel to typhoid fever. A case was read by Dr. Osler from the literature in which typhoid bacilli were found in the gallbladder eight months after the disease. In one of the cases operated upon here the gallbladder wall was almost sphacelated.

Our percentage of deaths this year in pneumonia is so far 26⅔%. It is below our average which is 29%. This is about the average in hospitals throughout the country.

Acute Pneumonic Phthisis resulting in Chronic Tuberculosis

Charles Butt (p. 149). This case was seen last year. It had all the features of pneumonia. We made two mistakes. He came complaining of cough and general soreness. We thought it was pneumonia and when shown to be tuberculosis we made the other mistake of thinking his condition to be much graver than it really was. He now has chronic tuberculosis but is in good condition.

DISPENSARY CLINIC

MARCH 11, 1897 — DR. OSLER

Mitral Stenosis

Andrew Freshline, age 11. He complains of pains in the abdomen and cough. The cough has lasted three weeks. *Family history.* Mother died of heart trouble. Brother died of heart trouble. Patient has had measles. This is the only sickness he remembers. He is a pale poorly nourished child and stands with his mouth open. *Inspection.* Thin. Scapulae winged (alae); round shoulders. The sternum is depressed; the clavicles are prominent. He has a long chest. There is marked scoliosis. The left shoulder is lower than the right. There is a slight precordial bulging and a diffuse cardiac pulsation. The left side measures in semi-circumference 39 cm. and the right side 38.5 cm. So the difference is more apparent than real as the two sides are about the same. From his general appearance

we can say that the scoliosis is due to general muscular weakness. Throat is examined. There is a granular condition. This is always suspicious. He has enormous tonsils with fissures. Adenoids are present. He has narrow nostrils and with mouth shut breathes a little audibly.

Palpation. The shock of the first sound is very plainly felt. The second sound is palpable. There is a presystolic thrill. This is very suggestive of mitral stenosis. A diagnosis of mitral stenosis is justified on the basis of a thrill in 98 cases out of 100; the Flint murmur in one of a hundred, and pericardial adhesions in the remaining one. One would not get the abrupt shock of the first sound in anything but mitral stenosis.

There is so often no history of rheumatism in these cases. Upon further inquiry we find he had chorea very badly several years ago. Chorea is associated with endocarditis more often than any other disease except rheumatism. No fatal case of chorea has been reported without endocarditis. The first sound is here preceded by a well marked vibratory presystolic murmur of increasing intensity ending in a short sharp snapping first sound. This is lost about the fourth interspace. It is scarcely heard inside the parasternal line, and disappears 1 cm. outside the mammillary line. The pulmonary second sound is accentuated. The second aortic sound is followed by a soft slight murmur which is heard better as we pass down the sternum. This is the murmur of aortic regurgitation and is diastolic in time. The pulse is very small. If it were aortic insufficiency with the Flint murmur, the pulse would be very strong. In aortic insufficiency there would be hypertrophy of the left ventricle also. Rare also, as Dr. Osler said on Tuesday, to have the aortic valve alone affected. So we know from these facts that it is mitral stenosis.

DISPENSARY CLINIC

MARCH 15, 1897 — DR. OSLER

A throbbing abdominal aorta occurs in:

1. Anemia. It may be astounding in this condition. The throbbing may even be communicated to the bed.
2. Aortic insufficiency.
3. Neurasthenia and hysteria.
4. Aneurism.

No grade of throbbing is so intense but that it may be associated with a perfectly normal aorta, as in cases of anemia. Don't make the diagnosis of aneurism of the abdominal aorta unless you feel a distinct pulsating tumor. Aneurism of the abdominal aorta is a rare condition. Osler sees twenty of the arch to one of the abdominal aorta. A patient in another room has a pulsating abdominal aorta, with transmitted heart sounds and a faint bruit. The aorta is on the right side but no tumor can be felt.

Chronic Nephritis

Bertha Hartshorn, age 18. She complains of a burning feeling in her stomach. She first came July 5, 1890, with chlorosis and remarkable swellings in the neck. She had a painless swelling for two years in her hands and recurrent fulness under her chin about every two weeks. She improved under treatment and the swelling disappeared. In October 1890 a swelling of the lower part of the neck developed. It was not connected with the thyroid gland. In 1893 she was admitted to the hospital with swelling of the lower part of the back. Albumin was present in the urine and there were granular and hyaline casts. There was no dropsy. In May 1893 she came again with swelling of the feet. The urine contained albumin and casts. In July 1894 she had "stomach trouble" consisting of pains in the abdomen. In 1895 she was here with loss of appetite and indefinite symptoms. She returned in March 1896 with chlorosis. The blood contained only 45% of hemoglobin.

Inspection. She is a healthy-looking girl. There are little fissures of the mouth. These are rhagades. They are seen in congenital syphilis, being a stigma of some value. But her nose is not flattened. It is straight and her teeth are very good. Furthermore she is not deaf, so there is no evidence of congenital lues here.

Her urine now has a specific gravity of 1010. One-tenth of one per cent albumin is present with hyaline and granular casts. There is 1% urea.

This case was referred to in Volume II of the *Johns Hopkins Hospital Reports,* p. 347 by Dr. Simon, in a paper on angioneurotic oedema. This disease, angioneurotic edema or Quincke's disease, is marked by localized swellings, rarely extensive and rarely dangerous. A hereditary forms exists. Osler reported a family in which five generations had been affected. Two cases in this family died of edema of the glottis. They are the only deaths on record.

Dr. Simon was right in regarding this case as one of chronic nephritis. In chronic cases with albumin in the urine but without any swelling the diagnosis of nephritis is often made by oculists who find an albuminaric retinitis present. The patient goes to the oculist complaining of spots before his eyes, etc. We would expect in this chronic case to have hypertrophy of the heart, high tension and general arterial thickening. This girl has a pulse of rather high tension and one can roll the radial artery under the finger. The aortic sound is markedly accentuated. The apex beat is well within the mammillary line.

Epitome. She has had chronic nephritis for six or seven years with swelling during the first two years; none since. She is not likely to have dropsy again.

Angioneurotic Edema

Annie Ticha, age 35 years. Admitted Mar. 2, 1896 with pain in the side and a remarkable swelling of the side. On Feb. 12, 1895 at the Dispensary she was found to have a swelling 10 x 12 cm. just below the axillary fold. There had been a

similar one on the hands several weeks before, accompanied by abdominal pains and some nausea. Nine days ago there occurred a swelling on the forehead which lasted six hours. No changes were found in the urine. She had no pain then in the abdomen. She comes now, however, complaining of pain in the " stomach " but has no area of swelling anyhere.

A very good article on angioneurotic edema by Dr. Norton appeared in the *New York Medical Journal*, 1897. The patient had two attacks of edema of the glottis. It is not an uncommon disease. It is closely associated with Henoch's purpura. In the family Osler reported every member had colic with the attacks. This also occurs in purpura.

Case XXVII. Typhoid Fever followed by Periostitis

Bone lesions occur as a sequela of typhoid fever. They are common, but appear late, perhaps months after the disease. Bacilli may live in the bones for years. They usually attack the long bones or ribs.

Bessie Massey (p. 65), age 20 years. She still complains of pain in both arms. There is very little swelling. It is curious how long the condition lasts.

AMPHITHEATRE CLINIC

MARCH 17, 1897 — DR. OSLER

Case XVIII. Pneumonia

Wm. H. Davis, age 24 years. Admitted March 14 with pain in the lower right axilla, with aching all over the body and cough. *Family History.* Father and mother died of phthisis. On March 9 he went to bed with chilly feelings. On March 10 he vomited. A cough developed March 11. March 13 he had epistaxis, which was repeated the next two days. The attack of pneumonia is thought to have begun on the 9th. On admission the symptoms just noted were aggravated and, in addition, he had diarrhea and headache.

He is a well-built man. There are the remains of herpes on the lower lip. Over the lower right side in back the resonance is impaired. The whole right lower lobe is involved, with intense tubular breathing and râles. There is a to and fro friction murmur heard. Heart. The second aortic and pulmonary sounds are accentuated. He became delirious twice. The urine showed albumin and pus casts. Today his condition is good. The temperature is down but not to normal. He had no delirium last night. The right side of the chest is flat and tubular breathing is very intense. The history of onset is very indefinite in this case. Often one can set the exact hour of the attack. There are two points to notice: (1) that he has tenderness of his abdomen, and (2) epistaxis. These are suggestive of typhoid fever but there are no rose spots on abdomen. It might be pneumotyphoid.

Case XVI. Pneumonia

Heinrich Peterson, age 36 years. Complained of headache, cough and pain in the side on admission March 11. The onset began March 9 with headache and dizziness. He had a distinct chill, also pain in the lower right side of the chest with cough and bloody expectoration. When admitted he did not look very ill. His pulse was 60, temperature 104° and respirations 24. The physical signs were well marked at the base of the right lung behind. Herpes labialis was present. The expectoration was tenacious and rusty. The next day after admission the sputum was very bloody and fluid. The leucocytes were up to 33,000. The temperature became normal at 2 p. m. on the 4th day. He had the initial chill just 4 days before at 2 p. m. We have had one case with the crisis on the 3rd day.

Case XVII. Pneumonia

Wm. Knouff, age 22 years. He woke up with a chill the night of March 4. Then had cough and sharp shooting pains on the right side with bloody expectoration. Over the right lower back resonance was deficient. Vocal fremitus was present.

There were tubular breathing and râles. Here we have herpes again. The crisis occurred the morning of the 10th day. The diurnal remissions of his temperature were very well marked; this being rather an exception to the rule. His temperature has been subnormal ever since his crisis. This is common. The maximum leucocyte count was 10,000. He feels well. His tongue is coated. He needs to have his bowels opened. Treatment: strychnine and whiskey.

Case XIX. Pneumonia

Nate Helfer, age 19 years. Complained of pain in the side of the chest and cough. He had a three hour chill March 12 and pain in the chest the night before. We date the onset from this chill at 9 a. m. on March 12. At the right apex there was tubular breathing and the right lower lobe was also involved. Herpes was present on the lower lip. On admission his temperature was 105°, pulse 140, respiration 44; so he was probably pretty sick. Leucocytes 30,000. The temperature was normal before the end of the fourth day. Temperature subnormal at end of the fourth day. Note crisis occurred at end of fourth day.

Pneumonia in Children

In children the diagnosis is sometimes difficult because the disease is centrally placed. The physical signs may not be developed until late in the disease.

Case XX. Pneumonia

Miss D. age 8 years. Family history. Father died of tuberculosis and one sister of tuberculous meningitis. Past history. On January 18, 1897 she had fever and frontal headache. She had a similar attack in February. Cough was a feature of both attacks. The child is delicate. The fauces are slightly inflamed. The percussion note is impaired at the right base behind and the breath sounds are harsher here. A croupy cough developed on March 11 and continued on the 12th. She became delirious

and vomited twice. On the 13th she was restless and the cough was severe. On the 15th there was active delirium. The cough was looser. Temperature that day fell to normal and has remained so since. She is all right today.

Acute Pneumonic Phthisis resulting in Chronic Tuberculosis

Charles Butt (p. 142), age 21 years. Bartender. He entered the hospital January 1896 with cough and general lameness. His disease set in with a chill on January 8. He had a marked consolidation at the left apex with signs of rapid softening. The local signs in acute pneumonic phthisis simulate pneumonia much more than do the general symptoms. This looked like a case of phthisis florida as he had night sweats, fever, elastic tissue and tubercle bacilli in his sputum. He improved much, however, while in the hospital, gaining 10 pounds and left in very good condition in April 1896.

He is pale now; fingers are clubbed; hands cold. The clavicles are prominent. There is flattening in both infra-clavicular regions; more on the left. There is a wide area of cardiac impulse. The resonance is defective under both clavicles, with flatness under the left. There are crackling râles and prolonged expiration under the right clavicle. Moist sounds are heard as low as the second rib. On the left side cavernous signs are present. They are loud amphoric moist sounds heard as low as the fourth rib. The heart sounds are very loudly communicated as high as the clavicle. There is extensive involvement all the way down. That it is a caseous consolidation with excavation there is no doubt, and probably a pleural thickening in addition. He says he has no chills or fever now. He coughs up greenish material. Temperature is 101° today.

This belongs to the third group of acute pulmonic phthisis, namely the one that goes on to chronic pulmonary tuberculosis.

DISPENSARY CLINIC

MARCH 18, 1897 — DR. OSLER

Aneurism of Innominate Artery

Richard Lee (pp. 67, 69, 75, 115). He was admitted about three months ago with urgent dyspnea. Three years ago he had an aneurism of the right femoral artery which was operated upon. He had a swelling in the left thyroid region which disappeared after the first bleeding of 500 cc.

Autopsy findings. There is a " milky patch " on the pericardium where attrition is greatest. This is common. The aneurismal sac was given off exactly at the mouth of the innominate artery in the very first part. The opening on the side of the sac is the continuation of the innominate artery. The trachea is much flattened and is concave in front. There is an intense tracheitis which is most marked one and a half inches above the bifurcation. There is a diffuse bronchiectasis with bronchorrhoea. An operation could have been performed in this case.

Cancer of the Stomach

Harry Mills, age 47 years (p. 157). Complains of " misery " in the epigastric region. Pain comes on after eating and disappears after a few hours. It is a griping nauseating pain but he does not vomit. He still has a good appetite. He has not lost weight, but thinks he has lost strength. That is important. His habits are good. His present illness began in November.

Abdomen is normal in appearance. The sides are symmetrical and flat; grooves are equal; respiratory movements regular. There is a visible pulsation of the abdominal aorta. (Sit on the right side when examining the abdomen as it is more convenient. Put the full hand on the abdomen.) There is distinct fullness under the left costal border. Between the left sternal line and the middle line, there is distinct resistance. Between the navel and the left costal border, as he draws a deep breath, there is a ridge-like mass that can be rolled under the finger

and occasionally can be seen. This descends with inspiration and varies in hardness. On inflation with carbon dioxide there is a distinct bulging in the left hypochondriac region. The tumor mass is now displayed to the right. Gurgling is felt in it. The tumor is probably at the pylorus. Ridge-like tumors are common there.

I. It throbs with the aorta.
II. It descends with inspiration.
III. It exhibits an intrinsic movement, namely peristalsis.
IV. It moves with change in position.

He should be given a test breakfast and the stomach contents examined. This is either hypertrophic cirrhosis or a scirrhus. There is not much dilatation of the stomach and hence not yet much constriction of the pylorus.

DISPENSARY CLINIC

MARCH 23, 1897 — DR. OSLER

Facial Paralysis in Syphilis. Rupia

Benjamin Franklin (p. 158), age 40 years. Laborer. Colored. He complains of cough and pain in the chest. In lifting his eyelids, the right forehead wrinkles markedly more than the left. He can shut the right eye more firmly than the left. Tell him to purse his lips and try to whistle. He has not been able to whistle for a year. Whistling used to be his great "play toy." In drinking he notices that he cannot hold fluid in the left side of his mouth. He puts his tongue out straight. Locate the middle line from the teeth, not the lips.

He had gonorrhea 8 years ago and a penile sore in Jan. 1896. It healed in a month. He had ulcers on his leg the winter before last and again this winter.

Inspection. There are several rupial crusts on the back and one on the leg that has just fallen away, leaving a definite excavated punched-out sore. Rupia leaves the brown pig-

mented scars. He has a pustular rash on his back. Above the left inner malleolus there is an ulcer the size of a quarter of a dollar.

The glands in the neck are enlarged and shotty. The epitrochlears are not palpable. He is a little deaf in the left ear, but much less so than formerly. No discharge from the ear. He had a roaring in his ear. Ticking of a watch close to the left ear is not heard.

Look up "Nervous affections in Early Syphilis" in Dr. Lydston's paper in the *Journal of the American Medical Association* for 1895. See also articles in the *Lancet*, Volume I, 1895 and in the *Transactions of the Medical & Chirurgical Society of London.*

It is too early to conclude that the facial paralysis is due to his syphilis. It may have resulted from his ear trouble. Many of the cases of progressive deafness in young children are due to hereditary syphilis. Besides this case Osler has seen four cases of facial paralysis in the last few years occurring in early syphilis.

Phthisis

Henry Schroeder, age 62 years. Complains of cough and pain. He says he cannot get any air. He has had a cough for one and one-half years and has lost strength and become emaciated.

Physical examination. He is much emaciated.. The clavicles are tilted up far. The suprasternal notch is very deep. The upper chest is somewhat rounded (emphysematous). The cardiac apex can be seen in the 5th space outside the nipple line. Pulsations are visible in the brachial arteries throughout their extent. With quiet breathing the chest does not move perceptably. Pulse 88; small volume; not recurrent; easily compressed; not collapsing. No capillary pulse is seen. A slight systolic thrill is felt. One gets the shock of the second sound. The aortic second sound is accentuated and there is a booming first sound. No murmur is present. In the back there is a great rattling in the bronchial tubes. Mucous râles are present

everywhere. There is flatness over the right clavicle. Myoidema is present. [This consists of a muscular spasm preceded by a local depression, and is very common in thin people. It occurs more frequently in tuberculosis than in any other condition.] Over the upper right lung there is dullness and harsh breathing. The sputum is to be examined for tubercle bacilli. The case is probably one of tuberculosis.

AMPHITHEATRE CLINIC

March 24, 1897 — Dr. Osler

A pleurisy complicating pneumonia may simulate a delayed resolution or a thickened pleura. The pleurisy is apt to be of the empyema type. The purulent and fibrinous exudates are the most common in pneumonia. The fibrinous layer may be creamy white and an inch in thickness.

Case XV. Pneumonia

O. M. Day (p. 134). There are two peculiarities in this case. The onset was slow and the defervescence was by lysis. The dullness persisted. It was not until the 14th day of his pneumonia that his temperature became normal. It touched normal on the 9th and was below normal some hours on the 11th. It fell to normal on the 12th and 13th and remained normal from the 14th to the 20th. On this day the temperature rose to 100.5° and he has had an irregular fever ever since. The fever has been up to 101°. Pneumonia has an uneventful convalescence as a rule, and thus differs greatly from the convalescence in typhoid fever. He has never looked quite satisfactory. His pleurisy has persisted. There is dullness to the lower border from the 5th rib in the right axillary line. The note is clearer at this point when he lies down than when he sits up.

Case II. Pneumonia

Corrected Diagnosis is Acute Pneumonic Phthisis

John McCarthy (p. 73). When he was here he looked very ill and was somewhat emaciated and had a pasty complexion. He had the physical signs of a consolidated lung. The voice sounds were transmitted with great intensity. The sputum was very glutinous. It had the typical rusty appearance seen in pneumonia and contained many red blood corpuscles; few of them altered. Slight leucocytosis. No tubercle bacilli in the sputum or elastic tissue. We thought it was a case of pneumonia with delayed resolution. He was seen Dec. 15 at his home. Dullness was then universal over the whole back. When seen later a dry friction rub was detected in the axilla. He died Feb. 16. During the last six weeks of his life he became very emaciated. He coughed a great deal and expectorated yellowish sputum. The family physician said he had consumption. He died evidently with the features of galloping consumption. The doctor was probably right, as the irregular onset, the rapid decline and death point to acute pneumonic phthisis . In these cases as Traube has pointed out the sputum becomes greenish after the blood disappears. The sputum is rusty early in the disease and later is green.

Forms of Chronic Nephritis

The cases with anasarca are due to the large white kidney, the amyloid kidney or chronic parenchymatous nephritis. In interstitial nephritis, dropsy is the last thing we see. The patients come complaining of all sorts of things and they die of everything but dropsy. But they may have dropsy from heart failure.

Chronic Parenchymatous Nephritis

Perry Taylor, age 10 years? Colored. Complained of shortness of breath and swelling of the abdomen. His habits are good. Past history. Measles, malaria and whooping cough. The present disease came on last April with swelling of the legs.

Shortness of breath developed in June. He get up twice each night to urinate.

On admission Sept. 12, 1896, he had edema of the legs and abdomen. The temperature was slightly elevated. The heart was normal. The second aortic sound was accentuated. The urine showed hyaline, pus and granular casts. The specific gravity was high, 1025, albumin 1.6%. On Oct. 5, 3000 cc. of fluid were removed by paracentesis abdominis. It was a pale fluid with a specific gravity of 1010. Later 4000 cc. of fluid were removed. Stimulants were given: brandy 1 dram; strychnine 1/30 gr. The amount of urine gradually increased until December when it reached 2400 cc. daily. It has diminished since then. Gastric symptoms have been at times severe. He has had several vomiting spells.

Treatment. He has been given digitalis, diuretin, potassium iodide, strychnine, whiskey and yesteday morphine.

He still has nausea and vomiting. He is drowsy and his general condition is bad. It is not common for these cases to run so acute and severe a course. The prognosis is very bad. He may have a uremic convulsion and die tonight. He has now great anasarca, nausea and vomiting.

These cases of chronic parenchymatous nephritis often start gradually.

There is no know etiology unless it be malaria. Chronic parenchymatous nephritis often follows fevers.

Chronic Parenchymatous Nephritis

Ida Amos, age 15 years. Admitted October 17, 1896, complaining of swelling of the legs, abdomen and face. Past history. Measles, mumps, and at the age of eight had scarlet fever. She noticed on June 5 swelling of the feet and puffiness of the eyelids. Has had chills and fever since this swelling of the feet began. With the exception of the swelling and pallor, she has felt quite well.

On admission there was marked pallor and edema of the feet, legs, and genitalia. The urine averaged 400 cc. in twenty-four

hours during the first week. There was 2.1% albumin; casts and epithelial cells were present. Hemoglobin increased under treatment and there was a gain in weight. Vomited for the first month or so. She became almost well in December, and the urine increased in quantity. Edema decreased under pilocarpine. In February she had 0.7% albumin; volume 1150 cc.; urea 12%. From the middle of February onward, she had frequent attacks of swelling. On March 18 she had a second attack of dyspnea associated with dullness in the right back. There was pure tubular breathing over the right lung. She died on March 20. Death due to pneumonia.

The duration of the nephritis was nine months. The onset was insidious. The blood count on admission was 1,600,000 red corpuscles per cmm.; white cells 4,000 per cmm. On March 11 she had the first attack of dyspnea and the volume of urine fell to only 80 cc. in twenty-four hours. The urea was 14.9%; albumin 2%. She was cyanosed and vomited. Sodium chloride was injected.

You do not save one out of three of these cases. Here there is a very different prognosis than in acute nephritis.

Acute Nephritis

John May, age 14 years. Complains of shortness of breath and swelling of eyes, face and limbs. He has had no nausea or vomiting. Urine showed albumin and casts.

This is a case of acute nephritis probably following exposure to cold. It is an early stage. He is much better. His edema has disappeared. He is passing a great deal more urine. He now passes more than 1000 cc. in twenty-four hours. He is taking buttermilk. This is an excellent diuretic and patients will often take it when they will not take milk. He has a sweat bath every day and sweats well. His color is not good yet but is much better than it was.

Nerve Symptoms in the Secondary Stage of Syphilis

Cephalalgia	3	(sixth week 1; fourth month 1; third month 1)
Neuralgia	2	(sixth week 1; fourth week 1; fourth month 1)
Symptoms simulating tables	2	(third month 1; seventh month 1)
Hemiplegia	4	
Paraplegia	6	
Mental symptoms	6	
Facial paralysis	1	(first year)
Hemianesthesia	1	(second year)
Facial hematrophy with deafness	1	(second year)
	26	

DISPENSARY CLINIC

MARCH 26, 1897 — DR. OSLER

Cancer of the Stomach

Harry Mills (p. 150), March 20. Gastric analysis. Total quantity obtained from stomach 90 cc. (normal 40-60 cc.). Bread of test meal was very little altered. Total acidity .2 cc. of 1/10 normal NaOH solution (normal 4-6 cc.) No free HCL. Trace of lactic acid found with Uffelmann's test.

Urine showed an increase of indican. Blood: red blood corpuscles, 4,620,000; leucocytes 8,000; hemoglobin 70%. Weight of patient 125¼ lbs.

March 27. Red blood corpuscles 4,620,000; leucocytes 10,000. Weight 126 lbs.

April 17. Weight 113 lbs.

May 1. Weight 118 lbs. Red blood corpuscles 4,300,000; leucocytes 8,000; hemoglobin 70%.

He says he has suffered from dyspepsia for years. This is a matter of importance to inquire about. On closer inquiry we learn that his digestion has been good. He complains of

"misery" in the region of the stomach. He has had no vomiting.

Beside the four movements noted on inspection of the abdomen when shown in the clinic March 18 (p. 150) a gurgling is felt on palpation. This is important as it indicates that a tumor is in connection with a hollow viscus containing fluid. What is felt increasing and decreasing under the hand is chiefly the hypertrophied muscularis near the pylorus.

Constriction of the pylorus results from: (1) kinking, secondary to inflammation of the gall bladder; (2) neoplasm (scirrhus); (3) scar tissue of a healed ulcer.

The blood count shows his blood is not in a bad condition. His color shows that. His appetite is good yet. No doubt this is a carcinoma. His chances for living a year and a half are excellent as his blood and digestion are in such good condition. An operation is not advisable. If he recovered from the effects of the operation, he would probably not live more than a year or a year and a half.

Treatment. He is given a prescription for gentian and hydrochloric acid.

Benjamin Franklin (p. 151). The facial paralysis came on one month after the initial lesion. No case has been reported as early as this. The muscles on the left side of the face responded more slowly and action is incomplete. Taste is unaffected on the left side. The membrane of the left ear is retracted. This would account for his deafness, but the auditory nerve might be affected also. This we could not determine. The secondary symptoms are twitchings and some retraction. It is called Bell's palsy being named for Sir Charles Bell, leading British anatomist, who demonstrated that the seventh nerve was the motor nerve of the face.

Facial Paralysis

Hamilton Smith, age 23 years, Colored. Admitted March 18, 1897 with pains in the joints. He had always been healthy. Gonorrhea four years ago. He denies lues. Four weeks age

he was seized with pain in the right hip; there was no swelling. Later there was pain in the left ankle and elbow and also in the left eye (iritis). The hearing was affected, and he had pain in the ear. The lymph glands became enlarged. There is slight pigmentation in the coronal margin of the penis.

March 22. A double middle ear catarrh was found. This day paralysis of the right side of the face developed.

March 24. Hearing much improved. All the electrical reactions of the facial nerve are present. It is rare to get a case of facial paralysis this early.

Inspection: There is hardly any difference between the two sides of the face. But he winks only with the left eye and wrinkles the forehead with the frontalis of the left side only. In closing the eyes, the orbicularis of the right eye does not contract at all. There is a slight movement due to Müller's muscle. (It is supplied by the sympathetic.) There is a slight movement of the ala nasi of the right side when he sniffs. When he laughs, he moves the mouth to the left side. Tongue when extended is in the middle line when its position is taken from the incisor teeth.

This is Bell's paralysis. The lesion may be anywhere from the cortex to the stylomastoid foramen. As the fibers of taste are not involved, the lesion here would be below the geniculate ganglion. There are supranuclear, nuclear and infranuclear forms of this paralysis, as classified by Gowers. In hemiplegia the upper branches of the facial nerve are not involved. In the supranuclear form also the electrical reactions remain unchanged. Emotional influences, such as asking patient to laugh, may cause contraction of the muscles. The usual seat of the lesion in hemiplegia is the internal capsule. In the supranuclear form the lesion may be between the cortex and the nucleus of the seventh nerve in the medulla oblongata.

That this man has had syphilis seems probable. The pains in his bones and the iritis point to this.

Sept. 10, 1897. He returns to the hospital with some intestinal disorder. The paralysis has disappeared.

AMPHITHEATRE CLINIC

MARCH 31, 1897 — DR. OSLER

Case XXII. Pneumonia

Jos. Hoffman, age 10 years (p. 171). It is now his seventh day. He had a flushed cheek on the side affected. There was an area of dullness down the right anterior axillary line. His leucocytosis was 55,000; the highest of the series. His cough has been severe. Probably tomorrow his temperature will be normal. He had 5 minims of digitalis every four hours as his pulse was weak. It is now good and quiet. A professor in Budapest reports a large series of pneumonia cases treated with large doses of digitalis. Good results were obtained. There is very little movement of the affected (right) side. The entire right back is flat. There is intense tubular breathing and good-sized bubbling rales.

The bad symptoms in pneumonia are : (1) a low count of leucocytes; (2) urgent dyspnoea; (3) toxic symptoms—relaxation of the vaso-motor system, sweating; (4) delirium; (5) weak pulse.

This boy had paragoric, one teaspoonful, to quiet his cough. Dover's powder usually allays the cough and quiets the nervous system. The outlook of pneumonia in children is very good. Cerebral pneumonia is more common in children. The head symptoms often simulate meningitis. In children the physical signs are often obscure.

Abscess of the Lung

David Gardner, age 57 years. On admission he complained of pain and weakness. He was taken with a chill and pain in the side of the chest January 3. In three weeks he was well. Three weeks after that he had a " dead, weak, tired feeling." He has been in bed ever since. He has had a cough and very foul sputum which he has expectorated in large quantity.

Over his left apex there is dullness. The left axilla is flat and

tymphanic on percussion and there is tubular breathing. The sputum is foul with a gangrenous smell and is greenish-black in color. The sputum is not as abundant now, and it is not as offensive as before. It separates into three layers. No tubercle bacilli or elastic tissue found. He has been spitting this up for seven weeks. He had an intense cough. He is much better now. In the left side of the chest there is a spot of great tenderness.

There has probably been a breaking down of the lung tissue with abscess formation. It is too early for bronchiectatic dilatations to have developed. There are probably several small cavities as large cavities would give the physical signs of cavity formation.

Intra-tracheal injections of a mixture of menthol 8 grains, guiacol 1 grain, olive oil 1 drachm have been followed by great improvement in chronic cases.

Sequelae of pneumonia in the lungs are gangrene, abscess and cirrhosis. All are very rare.

Case XXIII. Pneumonia

Mr. X———. Admitted March 7 for intestinal obstruction. He was operated on March 8. On March 29 he was seized with dyspnea and pain in the chest. His temperature was 103.4°; the face anxious and livid. He has pneumonia of the left lower lobe and it follows the anterior axillary line.

Surgical Pneumonia

Pneumonia often follows injuries. A man is hurt by falling off his wagon and pneumonia comes on in 36 hours. It is a very common occurrence in the old or debilitated who become injured. The case of Mr. X has no relation to his operation which was 21 days earlier. It comes under the group of cases that develop in the hospital. Several cases may appear in a single ward resembling a house epidemic. Another group is made up of cases following etherization. We have had several

coming on within 24 hours. Probably the prolonged anesthesia weakens the respiratory tissues.

Resumé: Pneumonia in surgical practice:

I. Following injuries. These cases are the worst.
II. Developing in the hospital.
III. Following ether anaesthesia.
IV. Contusion pneumonia following injuries to the chest.

Adherent Pericardium

The heart of John Williams who died of chronic tuberculosis was shown.

Adherent pericardium is extremely common. The diagnosis is often made when it is not there. On the other hand it exists often when unusupected during life. This was the case with this man. There are two groups of cases. In the first the hearts are hypertrophied due to the adherent pericardium. They are the largest hearts that we see. In the second group there is no hypertrophy. There is a thick adherent pericardium yet the heart is not larger than normal. Hope suggested that in this group the movement of the heart was not impeded as no adhesions to anterior mediastinal tissues existed. There was no anterior mediastinitis in this case.

DISPENSARY CLINIC

APRIL 1, 1897 — DR. OSLER

A report was read by Mr. Benson on " Late Secondary Eruptions in Syphilis." Erythematous eruptions may appear as late as the second year. The longer the mercury is given, the later they appear. Relapsing erythema is not usually accompanied by systemic symptoms. In our case erythema developed fourteen months after the infection.

A report was read by Mr. John Coe on " Chronic Mastitis in the Male." He was asked to look up the literature in reference to the case of hypertrophied mammae (Hamberger) shown February 9. (See p. 116.)

Chronic Tuberculosis. Congenital Lues

Hannah Williams, age 13. Colored.

I. She had uniform enlargment of the salivary, lachrymal and all the mucous glands of the mouth.

II. (a) She had an enlarged spleen; (b) interstitial keratitis; (c) nodes on the bones;—so she had congenital lues.

III. She had enlarged glands of the neck and tuberculous peritonitis. She was in the hospital off and on for three years.

Physical Examination: She is thin and emaciated. She is very pale. The tongue is coated. Breathing is very rapid. Glands about the mouth are not enlarged now. The left apex moves less than the right. There is dullness on the left front to the fourth rib. The note is slightly typmpanitic. Dullness over the entire left back. There is flatness of the right apex. The breath sounds are clear on the right side. On the left side there is tubular breathing and loud bubbling resonant râles with expiration very much prolonged. There is amphoric breathing. The loud gurgling râles are heard low down in the chest and way out into the axilla. The dullness may be due to: (a) thickened pleura or (b) scar tissue in a puckered apex; (c) infiltrated lung in the neighborhood. There is a large cavity here which may have formed rapidly from breaking down of a tuberculous pneumonia.

Signs of a cavity at the apex: (a) lessened movement (present in this case); (b) the clavicle on the affected side is more prominent; (c) flattening of the area; (d) on palpation lessened movement and increased fremitus; (e) the percussion note may vary from hyperresonance to the other extreme of absolute flatness (this is the most variable of all the signs); (f) amphoric cavernous breathing; (g) all sizes of resonant râles are present. The heart sounds may be loudly communicated. There are clicking sounds also synchronous with the heart beat.

DISPENSARY CLINIC

APRIL 3, 1897 — DR. OSLER

The Anastomotic Pulse at the Wrist

	Patients		Students	
	Number	Per Cent	Number	Per Cent
Neither	38	76	16	64
Both Arms	8	16	4	16
Right Arm	2	4	3	12
Left Arm	2	4	2	8
	50	100	25	100

Carcinoma of the Stomach

George Hupschmann, age 60 years. German. He complains of pain at the left costal margin. He cannot eat solid food. Vomits. He does not know his family history. He has lost 30 lbs. since Christmas. The loss of strength is marked.

The left lumbar region is slightly more prominent than the right. An epigastric pulsation is marked and diffuse. Tenderness is present in the left hypochondrium. (In palpating always begin outside the rectus and rub your fingers along.) A distinct mass is felt as low as the level of the navel to the left of the midline extending to the parasternal line. It is very hard, and is distinctly irregular. One cannot indent it. (This is important).

Mobility:
1. The mass moves with inspiration.
2. No intrinsic movements are seen or felt.
3. Area of aortic pulsation is wide.
4. The mass changes little with shift of position of patient.

Percussion over this area is tympanitic. No peristalsis noticed upon inflation of the stomach with carbon dioxide.

Think of: (1) Tumor on the anterior surface of the stomach.
(2) Colonic impaction. He says he has had no "Stuhlgang" since Christmas. Constipation.

(3) Peritoneal tumors.
(4) Splenic tumor. But this does not feel like the spleen: (a) no sharp edge felt here (when present that is distinct evidence of spleen); (b) no notch palpable.
(5) Kidney tumors may appear in this region.
(6) Tumors of the colon situated at the splenic flexure. These are very common.

The pylorus is normally palpable in very thin people with enteroptosis.

In dry pleurisy the movement of the affected side is restricted. On palpation one feels the rub. This is important.

DISPENSARY CLINIC

April 6, 1897 — Dr. Osler

Hemoptysis

Daniel Ryan, age 39 years. He complains of hemorrhages from the mouth. The family history is negative. Past history. He has been healthy. Denies lues. The first hemorrhage was 15 years ago while exercising. He spat up two or three mouthfuls of blood. Has had fifty hemorrhages in all. More the last year than in all the previous fifteen years. The last one occurred 3 or 4 weeks ago. It came on without apparent cause. He has had a good appetite all the time. He felt a little feverish while he was spitting up the blood and shortly afterwards. The greatest amount was a quart which he raised in ten minutes.

Hemorrhage may come through the mouth from the: (a) nose; (b) gums (we have had one from the gums): (c) tongue and cheek (rare) (Children may chew their cheeks during sleep): (d) pharynx; (e) esophagus. (This is important. We may have bleeding from dilated esophageal veins—hemorrhoids, so called. The bleeding may be very profuse. We have had two cases here of fatal hemorrhage from the esophagus); (f) stomach. (It may be due to a neoplasm, to ulcer, to extreme congestion of the gastric mucosa associated with cirrhosis of

the liver); (g) hemophilia; (h) scurvy (rare); (i) hemorrhage in the newborn; (j) children may vomit blood obtained from the mother's nipples; (k) trachea; (l) bronchi; (m) lungs.

We can exclude malignant growth here if not tuberculosis, and hemorrhage from the lungs may occur without its being due to tuberculosis. When the bleeding is from the lungs, patients often say it is not accompanied by cough but that it comes right up into the mouth. Read Andrew Clark's articles in the *American Journal of the Medical Sciences* 1888 on hemorrhage from the lungs in relation to arthritis.

Occasionally there is persistent bleeding from a mucous membrane. Our patient (p. 14) seen here early in the session had epistaxis for 35 years. There are cases of hematuria recurring for years without apparent cause. Sir William Gull called it epistaxis of the kidneys.

Dr. Osler saw yesterday a case of chronic purpura hemorrhagia with severe epigastric pain. The patient has never been without a purpuric eruption since she was young. For the last twenty-two years she has not had epistaxis, until yesterday when she had an attack and it lasted twenty-one hours.

This is a healthy-looking man. The heart and lungs are normal. Coagulation time was taken. This should always be done in these cases of obscure hemoptysis.

Carbuncle Complicating Diabetes

Ziegler. He has a large spreading carbuncle on the neck and diabetes. Seven per cent of sugar is present in his urine. In every case of severe boils and carbuncles, always examine the urine for sugar. Carbuncle is a serious complication of diabetes. The best treatment is excision. There is puffiness under his eyelids. This man feels very sick.

Aortic Insufficiency

Good color. Well nourished. He has arthritis but denies gonorrhea. A loud diastolic murmur is present and Corrigan's pulse. He has aortic insufficiency following rheumatism. The

prognosis in these cases of aortic insufficiency following rheumatism is often good. The compensation may remain perfect for years.

Congenital Syphilis. Gummata

Mary B., age 24 years. Housework. There are old gummata on the hand, clavicle and lower legs. Diphtheria twelve years ago. Measles. Deaf since 15 years of age. She is now totally deaf. There is a scar of a gumma on the right leg. She said she had sores there when she was 13 years old. The ones on the hand and clavicle have improved greatly under treatment with potassium iodide.

Pulsation of the Abdominal Aorta

A throbbing abdominal aorta occurs in: (1) hysteria; (2) neurasthenia; (3) aortic insufficiency; (4) exophthalmic goitre; (5) aneurism.

Chlorosis

Susie Koutz, age 16 years. Housework. Complains of weakness; no pain. She is short of breath when she goes up stairs. She has amenorrhea. She has always been healthy, but now has a very marked pallor. The sclera is pearly. The ears are very white. The lips are bloodless. She has been pale and weak for only two months. The radial pulse is small. There is a visable capillary pulse. She has palpitation of the heart but only when running. The hemoglobin is down to 20%.

Malaria

Christian Laubach, age 17 years. The patient is having a chill now. He is shaking. His hand are blue.

Chills occur in: (1) malaria; (2) acute infectous disease,—particularly pneumonia; (3) tuberculosis; (4) septic infections such as: (a) a cavity in tuberculosis; (b) pyemia and septicemia; (c) an abscess anywhere; (d) inflammation of the bile passages, etc.; (5) nervous chills in hysteria, neurasthenia and nervous breakdown.

His temperature under the tongue is subnormal. In the

rectum it is 100°. His chill is just beginning. His hands are very blue due to an extreme grade of capillary stasis. It is a local asphyxia. The stasis results from constriction of the arteries. The capillaries are dilated to their utmost.

Swaying of Head in Infancy. Nystagmus

Preston Homgust, age 8 months. Colored. He is a healthy child. Movements of the head began two months ago. The child looks a little pale. He is intelligent. His head sways from side to side. These cases of head swaying, head banging, or vertical movement are grouped together. The last is the most common. They worry the parents. Usually children get over them. The nodding is seen in imbeciles and in epileptics. We do not often see head banging except in idiots. Gee reported cases of children who would bang their heads against their pillows when asleep. This child has also lateral nystagmus. He sways his head 120 times to the minute. The excursion is a short one.

Syphilis. Restricted Movements of the Arms

Harry E., age 27 years. Brickmaker. Lumps are present on his arms. He has had them for four years. The long duration excludes new growths, farcy buds and acute infections. They are hard, firm, fibrous structures. Only three on the left arm, more on the right.

He complains of pain in the elbow joints and cannot extend his arms fully. He cannot flex the left arm fully, and cannot extend either arm beyond a right angle. There is no redness but great tenderness in front of the elbow joints. He has no fever.

He had a chancre in Oct. 1894 and indurated glands. He received thorough treatment. This might be arthritis. It may occur in secondary as well as in tertiary syphilis. Reference was made by Dr. Osler to the report on arthritis in syphilis by Mr. Harry T. Marshall, a member of the class. The lumps on his arms may be symmetrical gummas. The clavicles show

nothing, nor do the shins. He is a healthy-looking fellow. A gumma of the elbow has been mistaken for rheumatism by Osler. The patient is directed to rub his elbows with sweet oil morning and evening. Potassium iodide is prescribed.

Tachycardia

John Reichert, 21 years old. Farmer. He was treated here for subacute rheumatism. His feet and ankles were swollen. He gets short of breath. He has been at work, and has never gotten laid up from work. He has pain in the ankles and feet. There is no running from his penis. He denies lues. He now has rapid action of the heart. The rate is 31 to the quarter. He has felt his heart beating rapidly at times. He looks well. His color is good. His pulse has been felt before and known to be rapid. Look for signs of exophthalmic goitre. His eyes are enophthalmic. The thyroid is not enlarged. The apex beat is diffuse in the fifth interspace just within the nipple line. There is throbbing in the neck. He has dermatographia of moderate grade. His hands are cold and blue. Both heart sounds are clear. A soft short murmur is present at the base, being heard best over the pulmonary region.

We see tachycardia especially in exophthalmic goitre. Four features of exophthalmic goitre are: (1) exophthalmos; (2) enlarged thyroid; (3) rapid heart; (4) tremors. The tachycardia in this case is of doubtful origin. The man is a neurasthenic.

DISPENSARY CLINIC

APRIL 13, 1897 — DR. OSLER

Syphilis of the Liver?

Samuel Smith (p. 178), age 48 years. Colored. He compains of cough, night sweats and pain in the right side of the abdomen.

Family History. His mother died of hemorrhage from the nose. No lung trouble in the family.

Past History. He had a chancre 18 years ago. Much swelling of his feet about 5 years ago. Pleurisy 3 years ago.

Present Illness. In the spring of 1895 he had pain in the right side, increased on taking a deep breath and on coughing. The pain lasted three weeks or more. It was called pleurisy. Since then has had a return of the pain from time to time and night sweats. He has lost 20 to 30 pounds during the past 2 years. Previous weight was 178 pounds. Cough came on insidiously and is getting worse. He raises a little sputum, chiefly in the evening. It has never contained blood. He is subject to epistaxis. He has no shortness of breath. His appetite varies but is fairly good now. Never has pain in the stomach. He voids more frequently than formerly and rises several times at night to urinate. The urine is scanty in amount and is high colored. He is constipated. He admits he has been quite a heavy drinker at times.

Physical Examination. Patient is emaciated. The breathing is chiefly abdominal and the chest moves as a whole. Auscultation is normal over both lungs. There is a large mass in the right upper quadrant of the abdomen. It is flat on percussion and continuous with the liver flatness. The edge is rounded and slight elevations can be felt on the rough surface of the liver. The spleen is readily palpable. Its edge is felt 4 cm. below the costal margin. The examination of the abdomen is otherwise negative. The epitrochlear and inguinal glands are enlarged. There is a lump in the right epididymis. No urethritis.

No tubercle bacilli found in the sputum.

Comment. The liver is suggestive of a neoplasm or lues. A neoplasm of the liver rarely gives rise to an enlargement of the spleen. This is probably a case of syphilis of the liver.

(Notes of this clinic made by Mr. J. D. Madison.)

Leprosy

A woman, Mary Sampson (p. 171), came to the Dispensary the other day with what was thought to be tubercular syphilis, but scrappings showed leprosy bacilli. Leprosy is endemic in

Louisiana, the West Indies and Norway. This woman was in the West Indies 13 years ago. Dr. Douglas of Canada had the anesthetic form of leprosy for 40 years.

AMPHITHEATRE CLINIC

APRIL 14, 1897 — DR. OSLER

Case XXII. Pneumonia. Empyema

Joseph Hoffman (p. 160), 8 years old. The right middle lobe was involved on admission. The pneumonia extended to the entire right side two days later. We thought he was going to have his crisis on the ninth day but his temperature went up again. On Sunday a needle showed fluid was present. A rib was resected and 250 cc. of pus came away. Pneumococcus was found in pure culture. If we had known the purulent pleurisy was due to the pneumococcus we might have relied on aspiration alone. The only exception to the rule to treat empyema like abscesses elsewhere by free incision and drainage is a pneumococcus empyema in a child.

Leprosy

Mary S., age 29 years. Complains of swellings and superficial ulcerations. Her father lived here from boyhood. He was always healthy. He died of cholera morbus. Mother died at 40 with cancer of the breast.

This woman lived here until 16, then went to Georgetown, West Indies and stayed there two months. She has lived in Norfolk, Virginia and for the last seven years in Allegheny, Pa.

Her present illness began six years ago when spots about the arms appeared. They gradually developed to the size of marbles. They disappeared at the time of her only pregnancy. They almost disappeared when she had a miscarriage but increased again rapidly after this.

Examination. She looks older than 29. The face is expressionless. The eyebrows are absent. The skin is pigmented.

There is a brownish stain over the whole face. In spots near the hair and near the chin there is atrophy of the pigment. There is a fresh erosion and ulceration upon her ears. The skin of the forehead is thick and infiltrated. Nodules are felt over both eyelids. The skin over both sides of the face is infiltrated. Both cheeks show signs of scarring. A large flat nodule is present on the right cheek over the jaw. There is a fresh superficial nodule on the right cheek. It looks as if suppuration was going on. Over the nose there is a thickened scar. The skin here is smooth due to a fresh scar. Both lips are thickened; also both eyelids. There are few remnants of hairs in the upper eyelids. Conjunctivae are both clear. Right cornea and also the left are a little turbid. Both ears are thickened and there is a fresh erosion along the margin and the lobe. The lobe of the right ear is deformed as well as thickened. Dr. Mackenzie found some scar tissue in the pharynx and thickening of the epiglottis. The skin of the neck is brown. No tubercular nodules are present on the neck. The hands are greatly involved. The dorsal surface of the fingers are glossy and shiny due to scar tissue. On the back of the left hand there is a healing ulcer. Scar tissue on the knuckles does not allow full flexion. The nail of one finger is lost. There is thickening of the wrists with scar tissue on the back of the wrists. The skin of the forearm is pigmented in the areas not covered with scars. Nodular bodies are present with natural looking skin over them. The involvement extends up the back of the arms to the axillae. The ulnar nerve is not thickened. The feet and legs are involved. The nails are gone from two toes. Superficial ulcerations extend to the knees. Above the knee the diffuse macular staining is seen, shading off above into normal skin. Nodules are felt in the region of the macules. When she came in there were bleb-like pemphigus lesions. These break and form suppurative ulcers.

The facies is characteristic. Tubercular syphilis in advanced stages is said to simulate it closely, but the macular pigmentation is not seen in syphilis. There are several centers of leprosy in America. The most important is in Louisiana. It is de-

scribed fully by Joseph Jones. An article by Hyde in the *Aemrican Journal of the Medical Sciences* reports the distribution of leprosy in this country. In Louisiana there are 83 cases, in Minnesota 120. The settlers from Iceland and Norway brought the disease to Minnesota. California heads the list with 158, due to the presence there of Chinese. All are imported except those in Louisiana. In Tracadie, Canada there were 18 cases, when visited by Osler. Five cases have been reported in this city. Dr. Atkinson collected them. We are exposed to the disease by unrecognized cases coming from the Sandwich Islands and infected Chinese in this country. See Morrow's article in Volume III of the *System of Genito-Urinary Surgery*. Leprosy was introduced into the Sandwich Islands by the Chinese. In India, there are 100,000 lepers. In China, it is extremely common. The disease has gradually disappeared in Europe. This is very remarkable as in the Middle Ages it was very common, there being then 14,000 lazarettos in Europe. This woman was in Demara, where leprosy prevails, for two months. It was formerly thought to be as contagious as smallpox. This has been disproved. It is contagious in the same sense that syphilis is contagious. But accidental inoculation is more rare than in syphilis. In Ceylon in 100 years there has been no case among the nurses or physicians.

This is a typical example of tubercular leprosy. It is the most common and the most disfiguring type of the disease.

DISPENSARY CLINIC

April 22, 1897 — Dr. Osler

Tobacco Angina

Matthews (pp. 79, 125). He is much better. No attacks now. Does not chew tobacco any more.

Bell's paralysis. The original communication by Sir Charles Bell, published in 1821, was read by Mr. Walter R. Steiner. Bell discovered that a lesion of the motor nerve of the face (seventh nerve) caused facial paralysis.

Acid Dyspepsia *

Adam Beibettel, aged 39 years. German. Farm laborer. Complains of "pain and gas on the stomach." He has been troubled in the fall and spring for the last six years. After meals he feels better. He has not lost weight or strength. He is of temperate habits. He has very large crow's feet; the grooves of which are non-pigmented. He is a bronzed muscular healthy-looking man. He came to America 11 years ago.

Examination. The abdomen is flat. It is below the level of the costal margins. The respiratory movements are normal. The costal and iliac grooves are normal and the side lines equal. The pulsation of the aorta is seen on expiration. Half-way between the xiphoid cartilage and the navel there is an elevation, which does not move on inspiration. It is soft and smooth. (It is a fatty tumor.) Abdomen natural on palpation; soft. The sigmoid flexure is readily felt. There is no pain on palpation in the region of the stomach. Nothing is felt in the region of the pylorus. The upper limit of stomach tympany is at the lower border of the fifth rib, and it extends to three finger breadths above the navel. After inflation with carbon dioxide there is no distention of the abdomen. It becomes a little fuller in the epigastric region but stomach tympany descends only two finger breadths. Nothing is felt on deep palpation. No peristalsis is visible.

He has acid eructations which he says are very bitter. Give him 20 grains of bicarbonate of soda one hour after meals, 1 minim of carbolic acid, 1 minim of iodine and glycerine. This is a good prescription when there is a great amount of gas. No evidence of neoplasm here. He has not lost in weight or strength. This is a strong point against a malignant growth.

Heberden's Nodes

Kate Freedy, 49 years old. This is an extreme case of Heberden's nodes. They are bony exostoses, situated at the

* It should be borne in mind that prior to the introduction of the modern roentgenological examination, it was impossible to make the diagnosis in many cases of uncomplicated peptic ulcer. They were often erroneously diagnosed as acid dyspepsia or nervous dyspepsia. J. H. P.

distal end of the second phalanges. Balfour in his book the Senile Heart said they were urate of soda. Charcot has disproved this. They never extend to the other joints. They seem to promote longevity. Charcot thought they predisposed to cancer of the stomach.

Aneurism of the Aorta

James Armstrong, 63 years old. Colored. Complains of pain in the chest and pain running down his arm. He had scarlet fever and typhoid fever when a boy. He was a soldier in the army one year. He had syphilis. He is a very healthy-looking man. He is short of breath.

He is very sore and tender to the right of the sternum over an area 4 inches in diameter. There is a marked pulsation in the second and third left spaces, and tenderness; chiefly over the second rib. The maximum cardiac impulse is outside the nipple line. There is visible pulsation in the brachial, radial and subclavian arteries. No shock on palpation of the pulsating area in the chest. A double murmur is heard here. The diastolic murmur is very low pitched. A loud systolic and rumbling diastolic are present at the cardiac apex. If dyspnoea continues tomorrow we will draw off 10 to 15 ounces of blood.

If not an aneurism the only other thing it might be is aortic insufficiency with a dilated aortic arch. He has a Corrigan pulse. The sensitive bulging area points to aneurism. If it is an aneurism it is probably eroding the rib.

DISPENSARY CLINIC

APRIL 23, 1897 — DR. OSLER

Addison's Disease

Fred Wich (p. 130), age 10 years. He left the hospital about March 12. It was reported on April 3 that he was much better. He had chilly feelings on April 12 and again on the 17th. He was treated all this time with 2½ to 5 grains of quinine daily.

On April 19 he had a distinct chill on his way home. It is remarkable that he is so much pigmented.

Causes of pigmentation are: (a) malaria; (b) jaundice; (c) severe sunburn; (d) Addison's disease; (e) exophthalmic goitre (sometimes there is much pigmentation); (f) vagabond's disease; (g) scleroderma; (h) arsenic; (i) silver nitrate.

He is extremely pigmented—more so than one ever sees in simple malaria. His mother says he was pigmented long before he had the chills; in fact for the last five years. No history of vomiting or diarrhea. He is active and energetic; no asthenia. Father and mother have very fair complexions. He is darker today than at his last visit. Dark bronzing of the skin may be due to silver nitrate. One must be careful in its administration. His pulse is quiet; under 100. He is well nourished. He has pearly conjunctivae. Note whether his mucous membranes are pigmented. This is very important. The inner surfaces of the lips are pigmented and there is a little pigment along the gums and inside the cheek; there is none on the under surface of the tongue. On questioning him, he says he at times has a little pain in his back. The spleen is palpable. There is no abdominal tenderness. The right kidney is palpable. His blood count was up to normal in the hospital although he looks so pale. Red blood count 4,120,000; leucocytes 6,000; hemoglobin 53%.

Always examine the testicles in cases of suspected Addison's disease. His are negative; no lumps being felt. Genito-urinary tuberculosis is often present in cases of Addison's disease.

The pigmentation of the mucous membrane is very suggestive. Addison's disease has three features: (a) pigmentation; (b) profound asthenia; (c) gastro-intestinal disturbance. This last may be absent. In doubtful cases like this treat with tuberculin. He has been having 5 grains of quinine daily for a long time. Now give Fowler's solution, 2 minims three times a day. It is liquor potassi arsenitis.

May 22. Condition unchanged. He is perhaps not quite as deeply pigmented.

Gout. Lead Poisoning

Adam Schaff, age 36 years. Porter. He complains of pain in the ankles and swelling of the feet.

First laid up with trouble in his left foot. The next time the left foot became inflamed first; then both feet. Last winter he was laid up for several months. The family history is good. Past history: lead colic 15 years ago. He is exposed to lead poisoning now. He had only one attack of colic after he signed the pledge. After a time he began to drink again. Certain foods and alcohol predispose to gout. He has been pale for a long time. He has the saturnine cachexia.

Three years ago during the night he had his first attack. His big toe looked red and glossy and was very sore. The second attack occurred in February a year ago. It involved the same foot at first, then the other foot also. Third attack was at Christmas in 1896; the whole foot and big toe were swollen; one arm was also affected.

The whole great toe of the left foot is thickened and enlarged; the joint is much enlarged. The knuckles are thickened. No tophi are present in his fingers or ears. There is a very marked blue line on the gums, just at the free edge. The aortic second sound is accentuated. There are no murmurs.

Besides gout, lead causes arteriosclerosis. His arteries are slightly thickened. He must stop drinking. He must drink plenty of water and take potassium iodide 10 grains three times a day for two weeks. We will then give him iron as he is very anemic.

Chronic Gout

Robert Baker, age 49 years. He has had the disease since 1891 and has to use crutches now.

Cholecystitis

Mary Dehl (pp. 61, 71), age 54 years. She was shown last fall as a probable case of typhoid fever with cholecystitis. She was admitted in November with an irregular elevated temperature. Her temperature never became normal during her stay

in the hospital. She had persistent jaundice and tenderness over the right hypochondrium. The conclusion was reached that she did not have typhoid fever at all but cholecystitis.

She was admitted to the surgical side and a laparotomy performed. Nothing was found. She left the hospital in February. On April 15 she had a severe shaking chill. Since then she has had severe pain in the abdomen, with vomiting and loss of weight and strength. There is blood in the feces. She has severe pain which radiates to the back. She looks pale, weak and ill. The veins of the abdomen stand out. There is a mass in the right hypochondrium with a dome-shaped prominence to the right of the umbilicus. The costal margin bulges on the right side.

DISPENSARY CLINIC

MAY 1, 1897 — DRS. OSLER AND THAYER

Syphilitic Cirrhosis

Samuel S. (p. 169). Under treatment the liver has diminished a great deal. It now reaches 9 cm. below the tip of the ensiform cartilage and is 7.5 cm. above the umbilicus. On entrance it was 4.5 cm. above the umbilicus. One of the nodules on the chest was removed and proved to be either an atheromatous cyst or a true dermoid. It was not determined which of the two it was.

Cancer of the Stomach with Dilatation of the Stomach

John Larson, age 53 years. Swede. He complains of pain in the gastric region. The family history is negative. Past history: always healthy. He uses tobacco and alcohol in moderation. He denies venereal disease. For three years has had a heavy sensation in the epigastric region. It is a steady pain but he has had no sharp pain. The pain is not increased by eating. There has been no vomiting. (Always ask in regard to loss of weight and strength and ask separately.) Lineae atrophicae or lineae albicantes are present on the shoulder.

These can occur when there is sudden increase in weight as in myxedema. The lines may look blue and be very wide. It is common to have them over the shoulder as here. His color is good.

There is a mass in the middle region of the abdomen. It occupies the right and left hypochondria and the upper umbilical region. Peristaltic movements are visible. Respiratory movement and a transmitted impulse from the aorta are seen. Inflation with carbon dioxide reveals a dilated stomach. On deep expansion of the chest the lower margin of the mass sinks 8 cm. A test breakfast showed no free HCl.

The dilatation of the stomach and the marked peristalsis mean obstruction of some sort at the pylorus. The most common causes are scirrhus and cicatricial contraction of an ulcer. A floating kidney compressing the pylorus is the most common cause of dilatation outside of stomach disease.

Exophthalmic Goitre

The patient (see p. 53) now complains of being hungry all the time. She has pains above the left clavicle on exertion and difficulty in falling asleep at night. She sleeps until 10 a. m.; then her mother always has to wake her as she never wakes herself. Blood count: red cells 6,948,000; leucocytes 10,000; hemoglobin 74%; no eosinophiles. Cabot says the eosinophiles are increased in exophthalmic goitre. Pulse 116; respirations 32. A systolic murmur is present and the second pulmonic sound is accentuated.

Jaundice

Mack. He has no appetite. There is no change in his general condition. The border of the liver is readily palpable. The jaundice has deepened.

DISPENSARY CLINIC

MAY 8, 1897 — DR. OSLER

For the relation between gout and lead poisoning, see Oliver's Goulstonian Lectures 1893.

Myxedema following Exophthalmic Goitre

Two sisters were treated here; one with myxedema; the other with exophthalmic goitre. The exophthalmic goitre case returned yesterday with myxedema. Her goitre is much reduced in size.

Abdominal Tumor

Paul Kandler (pp. 181, 190, 193), age 54 years. Tailor. He complains of " stomach trouble " after eating, for the past four months. He has lost no flesh, and feels as strong as ever. Past history. Always well. He says he never needed a doctor.

He is a well-nourished man. Full abdomen. Note first the contour; next the abdominal breathing; then the costal and iliac grooves. A pulsation is seen at the xiphoid cartilage.

This may be due to: (1) the right ventricle; or (2) transmission from the abdominal aorta through a lobe of the liver. Corona venules are marked. (At the lines of attachment of the diaphragm, venules become dilated in chronic dyspepsia, etc. This was first described by Andrews of St. Bartholomew's. It is of no diagnostic importance).

There is a mass in the right lower quadrant of the umbilical region extending over to the right mammillary line and upward to above the level of the 10th rib. It descends in inspiration. One can move it mechanically. The mass falls over beyond the middle line when he lies on his left side. It it very hard; distinctly irregular on the surface. It is rounded apparently, and is about the size of a fist. Deep bimanual palpation shows it to be about 15 cm. in extent. There is defective resonance over the most prominent part of the tumor. The note is a flat tympany. (This indicates it is covered in part by intestine.) The spleen is just palpable. The mass does not pass deeply into the renal region. It cannot be pushed so far over into the flank as to be grasped by the hands. (This is important in distinguishing it from kidney). The edge of the liver is readily felt in the right nipple line. In the middle line the mass can be readily separated from the liver. The tumor can be pushed

up so far that it is entirely above the transverse navel line. It cannot be pushed down so low that the upper border is entirely below the transverse navel line. No pulsation of the mass. Inflation does not cause the outlines of the tumor to become more distinct. It is apparently not connected with the stomach. After inflation note if there is gurgling in the tumor mass. There is none in this case.

Pyloric tumors may be in any region of the abdomen. Fagge records one tilting over the pelvic rim. The urine must be examined as the mass may be a floating kidney. The presence of blood in the urine would be important. The stomach juice and blood are to be examined. It is probably a lymphosarcoma growing from the solid structures such as the mesenteric glands. It is too movable for a retroperitoneal tumor. If urine and gastric juice are negative an exploratory operation would be justifiable. If it were connected with the intestines, one would expect signs of colic.

DISPENSARY CLINIC

MAY 12, 1897 — DR. OSLER

Abdominal Tumor

Paul Kandler (pp. 180, 190, 193), age 54 years. His blood contains 83% hemoglobin; 4,445,000 red blood cells; 6,000 leucocytes. The urine is negative.

The common phantom tumor is an intermittent hydronephrosis. Osler does not think that a floating kidney enters into the possibilities here. Two chief malformations of the kidney are the conglomerate (unsymmetrical) kidney and the horseshoe kidney. Either may be mistaken for a tumor. Dr. Polk removed an unsymmetrical kidney thinking it was a floating kidney. (*New York Medical Journal*, 1883.) The patient of course had no other kidney but lived 11 days before dying of uremia. No symptoms developed for 8 days. This may be a tumor of the retroperitoneal glands, mesenteric glands, omentum or the intestines. There are no gastro-intestinal symptoms,

however, but these depend entirely on how much the lumen of the intestine is occluded. So we cannot exclude tumor of the intestine. A diagnosis cannot be definitely made. It is apparently a solid tumor and readily movable. An exploratory operation is advised.

Cretinism

Theresa Seichmann, age 3. She came here first May 9, 1896. She had never walked or talked but she seems to understand everything. She had a very sallow waxy tint to the skin. Her tongue was large and protruding. Her abdomen was very large. Her mental development is much retarded. She can now say only a few words. She was given thyroid extract, grain 1, three times a day and then began to lose flesh rapidly. She is now much improved; looks brighter. She still has a slightly cretinoid appearance. She is just able to stand.

This is sporadic cretinism, in contradistinction to endemic cretinism. Sometimes it is congenital. Children are born in this bloated myxedematous condition. Usually the condition is not noticed until the end of the first year. It is very noticeable by the second year. After three years the child entirely fails to develop and remains a hopeless idiot.

Spastic Paraplegia of Infants

John Truffer, age 8 years. He complains of inability to walk. The family history is good. This is the third child. It was a 7 months baby. There were no miscarriages before the birth of this child; nine miscarriages since then. He began to talk at one year. The patient has had constant dribbling of urine since infancy. He has never been able to walk a step. He can talk and answer questions intelligently. The facial expression is good. The teeth are well formed. He keeps his mouth shut. He has a marked lordosis. There is distinct resistance on moving the arms. Both arms are spastic. He cannot move his arms and the same rigidity is present in the legs. There is marked adductor spasm. The knee jerks are markedly accentuated.

This is Little's disease or spastic paraplegia. Heine as early as 1840 described it very well. Little, an orthopedic surgeon of London, described it more fully. It is always a birth paralysis. It may result from failure of development of the motor paths, but is usually due to accidents connected with labor. It is more common in primiparas and in forceps cases, and in prolonged labor. It is probably due to hemorrhage in the cortex. Syphilis is an important etiological factor. There is usually much lack of mental development. This child is unusually bright. Often this condition is associated with athetoid movements. The only help is from the orthopedist.

AMPHITHEATRE CLINIC

MAY 12, 1897 — DR. OSLER

Addison's Disease

Dr. Osler now has 9 cases observed by him either clinically or anatomically. This is unusual, as it is a rare disease in America. We had two in the Johns Hopkins Hospital in negroes which were not recognized until the autopsy. One was a case of sudden collapse. At autopsy the only lesion was caseation of the adrenal. In the second case the mouth was pigmented. There was tuberculosis of the testes and adrenals.

In one case there was a gain of 17 lbs. in three months on adrenal extract. That was two years ago. The patient now works and feels well. On admission he had asthenia, bronzing, etc. The improvement was due no doubt to suprarenal extract. At times it does no good. *Pigmentation, asthenia and causeless vomiting* are the tripod of symptoms in this disease. The prostration is awful. Eight recoveries from Addison's disease due to adrenal extract have been reported in the last two years. This is a good result.

Pneumonia

So far we have had 8 deaths out of 28 cases. The sputum in acute pneumonic phthisis is green. Hanson (pp. 128, 135) had

tubercle bacilli in his sputum. They were found on the 12th day. He died on the 43rd day.

Case XXVIII. Pneumonia. Death

John Watts, age 48 years. He has been healthy in the past. He is a drinker. He worked to April 23 when he was seized with pain in the limbs and giddiness. On April 24th he had a bad cough. In the afternoon he was seized with pain in the abdomen and back, which was increased on coughing. He went to bed. On April 25 he had dyspnea, nose bleed and headache; no sputum. Admitted on the 6th day of the disease; temperature 102.5, pulse 108, respirations 40.

Examination. Face flushed. Herpes labialis. On admission the right axilla was dull; tubular breathing was present. Leucocytes 32,000. His condition was good; no delirium. The next day the pulse was feeble, weak and irregular. Given digitalis tincture; ten minims every 4 hours for 24 hours. On May 3 the consolidation had extended along the right anterior axillary line. The breathing was tubular. He did not look well. He was sweating. The pulse was very feeble. Leucocytes 63,000. Active delirium. May 4 Leucocytes 45,000. He was more rational but on May 5 and 6 he was again delirious, and the consolidation had extended. The lower left side was a little involved as well as the right. The pulse was feeble. Digitalis and strychnine were given. Temperature 102° to 103° He died of asthenia May 6, the eleventh day of his disease.

Autopsy. The entire right lung is solid from apex to base. There is gray hepatization above and red below. The left lower lobe is the seat of some consolidation in the stage of red hepatization.

This year our mortality in pneumonia including sequelae is 28.5%. Usually in hospitals it is 25% to 30%; also in jails, other institutions and in armies. Pneumonia is the most acute disease nowadays. We cannot cure it. Most patients die of toxemia.

Chronic Arthritis in a Child

Young girl. Her father died of rheumatism. She had measles when she was one year old. Arthritis began after measles one and one half years ago. She had swollen feet and inflamed joints. Then the neck on the left side became swollen and she noticed her sleeves were tight. There was pain in the hip. The arthritis was at first subacute. One year ago it became acute with fever and delirium. She was confined to bed for four months. In April 1896 she had pain in all the joints. They were swollen. She had sweats and could not walk.

There is no fever now. She is well nourished. The wrist joints are swollen. The metacarpal and phalangeal joints are also swollen a little. The elbows look large but their mobility is perfect. The enlargement is due to the epitrochlear glands. Both knees are affected. The ankles and toes are not affected. The thighs are widely abducted and everted. The knees are symmetrical and smooth. The outline of the joint is lost. The thigh muscles are atrophied. There is spasm of the muscles about the hip. Ankylosis is complete in both hips. There is some motion in the right knee. There is no soreness of the hips. Glands in the groins are involved, also the neck glands and the supraclavicular but not those in the axillae. She can flex the head but lateral motion is slight. There is no creaking of the joints. The spleen and liver are not palpable. The heart sounds are clear.

Chronic arthritis in children results from: (1) chronic rheumatism after acute (rare); (2) arthritis deformans (not uncommon) from the age of two to ten; (3) post-febrile arthritis after scarlet fever, measles and smallpox. I do not mean a suppurative but a chronic arthritis; (4) syphilis; (5) tuberculosis. Syphilis is not an uncommon cause. It usually involves the knees. Chronic tuberculosis rarely involves all the joints but we do see it involve all the large joints. This patient has neither a syphilitic or tuberculous facies. There is no syphilis in the family but the epitrocheal glands are very large. Diagnosis: tuberculous arthritis or post-febrile arthritis resulting from

measles. We will give the tuberculin test. Treatment: wet pack; rub at intervals. Passive movements. Hydrotherapy is best for joint lesions.

DISPENSARY CLINIC

MAY 13, 1897 — DR. OSLER

Tuberculous Pleurisies

1. Acute pleurisy the result of direct extension from the lung in well-marked phthisis.
2. The majority of acute ordinary pleurisies with effusions.
3. Acute suppurative pleurisy. This is rare.
4. Acute tuberculous pleurisy as a terminal infection. It is seen especially in patients with cirrhosis of the liver and in other bedridden individuals suffering from chronic diseases.

Strauss found in the Charité in Paris 9 of 29 ward tenders had tubercle bacilli in their nostrils. In Paris 75% of all the bodies that were picked up and brought to the Paris morgue had foci of tuberculosis.

Cirrhosis of the Liver?

Thomas Yelt, age 60 years. Finn. Admitted the first of May 1892. Discharged June 6. He had pain in the abdomen and occasional vomiting and 15 days before admission vomited 2 pints of dark clotted blood. His stools for several days contained blood. He was extremely weak. No fever then. He must have had a profuse hemorrhage as his lips were blanched and the skin yellow. Liver dullness was reduced. The test breakfast was dispensed within the hour. Weight 213 lbs. on admission; 200 lbs on discharge. He was readmitted in October, 1892. He had worked all summer and had been free from pain. In September, 1892, while lifting, he felt a cramp in the abdomen; he vomited, but there was no blood in the vomitus.

That was over four years ago. He looks very healthy now.

He has a fine slow full pulse. The most common cause of hemorrhage from the stomach in adult life is cirrhosis of the liver. But he does not have the Bardolphian facies. His nose is not red nor are dilated venules present. They are rarely missing in old cases of cirrhosis of liver.

Examination. A transverse ridge or fold can be felt in the abdominal wall. Nodular bodies are palpable in the middle line. They are preperitoneal herniae or lipomas or fibrolipomas. They yield no impulse on coughing. These are undoubtedly lipoma or fibrolipoma. The left knee is swollen and painful. There is some fluid in it. Treatment: Paquelin cautery. He comes to the hospital for treatment of his knee.

In cirrhosis of the liver blood may come: (1) from diapedesis through the mucous membrane of the stomach or the intestines, without any erosion; (2) from varicosities of esophageal veins. The bleeding may be extreme. Hemorrhage may occur very early in the establishment of the collateral circulation of which the esophageal and diaphragmatic veins form a large part; (3) hemorrhage in ulcer of the stomach. If the ulcer is just outside the pylorus in the duodenum there may be none or only slight hemorrhage from the stomach with a large amount from the intestines. Hemorrhage from the stomach also occurs in purpura. Usually, however, it is due to varices in the esophagus. This patient was thought in 1892 to have an ulcer of the stomach but he has had none of the subsequent symptoms such as pain, which an ulcer would have caused. The first symptom of cirrhosis of liver may be a profuse hemorrhage from the stomach.

DISPENSARY CLINIC

MAY 22, 1897 — DRS. THAYER AND OSLER

Cachectic Purpura

Case presented by Dr. Thayer.

Philip Kaiser, age 69 years. He is a feeble-looking old man with red spots on his leg. There is a very marked general arteriosclerosis. He had deep red spots on the back of his hand

which came without scratching. No distinct history of rheumatism. Small purpuric spots are common in malignant infections (intoxications). This man is debilitated and has not been able to work for 6 months. This type of hemorrhage in the skin is cachectic purpura. It is usually seen on the backs of the hands. Here it is well marked on the legs and probably on other parts of the body.

Observations on Purpura

Discussion by Dr. Osler.

There is no classification of purpura. We simply group the cases: (1) Purpura simplex. It sometimes does not amount to anything. It may recur in children. Purpura may be associated with errors in diet; especially from eating too much starchy food. Dr. Osler saw a child with a swollen gums, ashy color and purpura. It was actually scurvy. The child had been fed for a year on grits with a minimum of milk and a maximum of sugar and potatoes. A case of scurvy in a woman who lived for a year on bread and tea was admitted to the hospital with hemorrhage from the uterus. The various forms of proprietary condensed milk and preserved foods for infants cause infantile scurvy to develop. In scurvy we see hemorrhages under the periosteum. (2) Purpura occurs in chronic wasting diseases, as cancer, tuberculosis, etc. This is cachectic purpura. (3) Toxic purpura. The poison may be of a varied nature. It may be any one of the infectious fevers. It may kill before the disease appears. Twice Osler did autopsies in supposed cases of spotted fever which proved to be black smallpox. Snake bite is another cause of purpura. Phosphorus poisoning leads to hemorrhages from the mucous membrane rather than purpura which is bleeding into the skin. (4) Purpura is associated with arthritis as a marked manifestation. There may also be gastro-intestinal manifestations associated with the arthritis.

There are two chief groups of purpura: (1) one with arthritis. It is purpura (peliosis) rheumatica or Schönlein's disease; (2)

the other is Henoch's purpura. Schönlein was professor in Berlin about 1850. A skin disease is also named after him. There may be a polyarthritis, and urticaria may be associated with it or edema. It is difficult to decide whether we have purpura with arthritic manifestations or rheumatism with purpura. Henoch's purpura also usually has some arthritis associated with it. These may all run up to the most severe form—the purpura hemorrhagica. This is purpura associated with hemorrhage from the mucous membranes. Any simple purpura today may become fulminant tomorrow. All these forms may occur spontaneously. They have no hereditary bias or anlage.

Hemophilia is the form of bleeding due to a general depravity that is constitutional and hereditary. There are families of bleeders in this state and in Massachusetts. Occasionally a case crops up in a child of healthy parents. In a bleeding family the boys bleed, but it is transmitted almost exclusively through the girls. In the Appletons of Reading, Massachusetts, the bleeders can be traced back 200 years. The patients with hemophilia are liable to arthritis. They may have hemorrhage into the joints.

The skin lesions of purpura are polymorphic.

Persistent Epistaxis

Geo. Battenfield, age 57 years. Seaman. His father had frequent attacks of epistaxis; often 4 or 5 times a day. His sisters and brothers are also affected. His mother is living and well at 91. He had a primary sore 30 years ago and soon after that paralysis of the arm. Bleeding began when ten or twelve years old. At one time he was not able to work for two or three years on account of weakness. He has been bleeding two or three times a day. He does not remember a day that he has not bled from his nose. No history of subcutaneous hemorrhages. None now except one over inner condyle of right arm. This is an example of persistent recurrent epistaxis of a familial form. The sisters are affected. He had been bleeding since boyhood and is now quite anemic. He has dilated venules over the face and ears, etc., just as the man from Kentucky had.

These are often cases of purpura haemorrhagica. We will see whether this man has had cutaneous haemorrhages or not. He has not had them. See Osler's section on purpura in Pepper's *System of Medicine.*

In one of Prof. Wright's cases the coagulation time was retarded to 55 minutes. His cases were markedly benefited by taking calcium chloride.

Purpura Rheumatica. Schönlein's Disease

Ed. Allen, age 42 years. Two days ago a crop of purpurie spots came out over his legs. This is simple purpura. Over the right flank the hemorrhagic areas appear as large raised blotches. He suffers a good deal of pain. Morphine is given to quiet him. He could not keep the salicylates on his stomach. It is a question whether his is acute rheumatism with hemorrhagic manifestations or purpura arthritica. In favor of the latter is the fact that his temperature is only 99°.

DISPENSARY CLINIC

MAY 25, 1897 — DR. OSLER

Abdominal Tumor

Paul Kandler (pp. 180, 181, 193). In making the differential diagnosis we had practically excluded stomach, spleen and kidneys. The tumor was very movable, so that fact made its origin from retroperitoneal structures improbable, although Osler once saw a very movable tumor that arose from the abdominal aorta to which it was attached by a pedicle. Kandler's tumor was irregular and had a nodular surface, so we concluded it was a solid tumor and not a cyst. He was operated on this morning and it was found to be a tumor of the mesentery.

Acute Torticollis

F. Jargens, age 12 years. He complains of swelling of the neck and stiffness. The back of the neck is the part affected.

At onset he had swelling of his eyes. His mother died at the age of 26 of consumption. None of the children has had meningitis. There are four other children. There is no swelling under the eyes now. The tongue is a little coated. There is no swelling in the parotid region. The glands behind the sternocleidomastoids are enlarged; more on the right side than on the left. The parotids and submaxillary glands are not swollen. He cannot bend his head far forward and lateral movements are restricted. The forward movements are most impaired. His attitude with the head to the left and turned over to the right shoulder is the attitude of torticollis. The left half of the occipital bone is the most depressed. His head has been held twisted only since Sunday morning (3 days). There is no tenderness over the cervical spine. It does not hurt him to swallow. His throat should be examined. There the four or fifth cervical vertebra can be felt. It is important to examine them as tuberculous caries is so often overlooked. The tonsils are a little full. There are plenty of adenoids in back but none project into the pharynx. The back of the wall of the pharynx feels a little soft, but Dr. Osler does not think the bones are affected. There is no distinct swelling in front of the bodies of the vertebrae. The abscess in caries often projects into the retropharynx. Temperature 100.6°. Directed to put a mustard leaf on the back of the neck. Counterirritation is good if the case is rheumatic in origin, but this may be something more serious.

Read the article by Dr. Richardson on torticollis in the *American Journal of the Medical Sciences*, 1896.

Chronic Adhesive Pericarditis?

William Dill, age 43 years. He complains of shortness of breath and cough. If the third symptom, swelling of the feet is present, the tripod is completed and the diagnosis of heart trouble can be made. He says he has never had swelling of the feet.

Examination. There is marked precordial impulse in the

3rd, 4th, 5th and 6th interspaces, and in the left side of the xiphoid angle. There is marked retraction of the intercostal spaces. His color is good. He has not stopped work and this his hands and face indicate. That his heart is probably enlarged rather than displaced we can say from inspection. The apex beat is way out in the anterior axillary line. A thrill is felt in the mitral area, and it is present in diastole. We have not the loud shock of the first sound here. No active throbbing pulsation in carotids or brachials, but a slight pulsation can be seen on close inspection. The thrill makes us think of mitral stenosis. But one may get a thrill in aortic insufficiency with great dilatation, and in certain cases of pericardial adhesions. Here we have an immensely enlarged left ventricle. He has no Corrigan pulse. Broadbent's sign is well marked in the 10th and 11th spaces. The radial pulse is slow, and a little irregular; high tension. There is a very loud systolic murmur at the apex propagated into the axilla. There is a presystolic murmur of maximum intensity at the apex. The sounds are clear at the aortic area. The pulmonary second sound is very accentuated. Along the left sternal margin there is a very loud breezy systolic murmur.

He had rheumatism when 18 years old. It is a strong probability that he at that time had endo- and pericarditis. (1) The wide area of impulse; (2) the bulging; (3) the systolic retraction and (4) Broadbent's sign are the evidences of pericarditis. There has been high tension then on the pulmonary artery for 25 years. This has probably caused a little thickening and a little curling until now very likely there is relative insufficiency of the pulmonary valve segments. To this the breezy diastolic murmur is due. It was described by Graham Steell of Manchester.

He has not been able to do a day's work for five years.

AMPHITHEATRE CLINIC

MAY 26, 1897 — DR. OSLER

Abdominal Tumor. Found at Operation to be a Sarcoma of the Mesentery

Paul Kandler (pp. 180, 181, 190). The tumor did not seem to be connected with the stomach, kidney or spleen. We excluded the intestine as the seat of the tumor: (1) as there was no evidence of intestinal obstruction. This would have caused hypertrophy of the gut above the obstruction resulting in visible peristalsis and distention of that portion of the intestine; (2) he had never had colic or (3) hemorrhage from the intestine. The tumor after removal is not as large as it seemed to be before operation. It is entirely a mesenteric growth. Several feet (7 feet, 1 inch) of intestine were removed with it. You can tell the ileum from the jejunum in the dark as the valvulae conniventes can be felt through the walls of the jejunum. The tumor is a solid fibrosarcoma. The danger now is from a damaged blood supply to the intestines.

The most common tumor of the mesentery is caused by tuberculosis of the lymph glands, which is seen especially in children.

The Heart of Aortic Insufficiency. Autopsy Specimen

Female. Colored, age 54 years. Pedlar. The endocardium of the left auricle is always opaque. The auricular appendix of the left heart is much smaller than of the right. The anterior flap of the mitral valve is very large and looks different than any other segment. It gives the diagnosis at a glance.

Here there is great dilatation and sclerosis of the arch of the aorta. Both aortic and mitral valves are thickened and sclerotic. The lumen of the coronary artery is diminished.

There are two groups of aortic insufficiency: (1) endocarditic resulting from rheumatism (2) arteriosclerotic.

The patient died suddenly and unexpectedly. She had been in the hospital several times with swelling of the legs. She

had not had syphilis, but had been a hard worker and drank. Hard work combined with hard drinking predisposes to aortic insufficiency as much as lues does.

The Flint murmur, present in some cases of aortic insufficiency, is presystolic. It is rough, blubbering and interrupted, and thus simulates the murmur of mitral stenosis.

Exophthalmic Goitre

James Heller, age 25 years. He has a very marked exophthalmos. The right eye is a little more prominent than the left. The pressure of brain tumors or pulsating tumors at the back of the orbit can produce exophthalmos, but by far the most common cause is Graves' disease. Do not call it Basedow's disease as Graves was the first to describe it fully.

There is not much goitre here. The chief symptoms in exophthalmic goitre are goitre, exophthalmos and rapid pulse. His pulse is 88; so he has no tachycardia. Look for the fourth cardinal symptom—tremor. A minimum amount of tremor is present here. His eyes converge well. An important eye symptom—retraction of the upper lid is present (Stellwag's sign). Neither Graefe's or Joffroy's is present. Von Graefe's sign is the failure of the upper lid to follow the eyeball in downward movements of the eye. Joffroy's sign is the absence of wrinkling of the forehead on suddenly turning the eyes upward.

He complains of shortness of breath and rapid action of his heart on slight exertion.

Physical Examination: The first sound at the cardiac apex is rather humming. No murmurs. A soft bruit is heard over the thyroid gland. No dermatographia. No signs of especial nervousness. It is rare to see in Graves' disease a patient with this degree of placidity. He has only noticed his protruding eyes for six months. It is unusual to have so much exophthalmos with so slight enlargement of the thyroid and the other symptoms so mild. No area of dullness over the manubrium. The thymus is often persistent in exophthalmic goitre.

Exophthalmic goitre is a disease of the thyroid gland. Those

methods of treatment are best that diminish the gland, such as ligating its arteries or exposing it and thus causing it to shrink.

Myxedematous patients are placid. They have a slow heart action and their temperature is always subnormal. Myxedema is the antithesis of exophthalmic goitre with its rapid heart action, extreme restlessness and temperature often a little elevated.

The treatment of exophthalmic goitre is very unsatisfactory. Belladonna is perhaps the best drug. An ice bag should be kept over the heart continuously.

Graves described the disease in the *London Medical Journal*, Volume II, 1835. He published a later description in his Clinical Lectures in 1843. Graves in one case heard the heart sounds while standing four feet from the patient. Basedow described the disease in 1840. He first noted the tremor, the discovery of which is usually attributed to Charcot and Marie, 1883.

LECTURE

MAY 15, 1897 — DR. OSLER

Abdominal Outlines

Holden's *Landmarks, Medical and Surgical* is recommended. Quain's *Anatomy* is good, but not as good as Holden's. Methods of delimiting the abdomen vary a good deal. The ordinary English method: (1) Infracostal transverse lines are drawn across the abdomen parallel with the cartilages of the ninth ribs. (2) The biiliac line is drawn horizontally from the highest point of each iliac crest. Two vertical lines are drawn from the cartilage of the eighth rib on each side down to the middle of Poupart's ligament. The abdomen is thus divided into nine zones. A chart from His's *Die Anatomische Nomenclatur* shows the German method. A line is drawn from the tenth costal cartilage on each side to the spine of the pubes. The biiliac line is the same as in the other method. His's method defines the regions better; especially the hypochondrium as in

the ordinary method all the hypochondriac zone is not beneath the ribs.

The length of the thorax varies greatly. In some the costal margin is very close to the iliac crest. In others there is a space of four inches or more between the two.

In the epigastric region is located a large part of the stomach; the cardiac orifice and the pylorus usually, when the stomach is empty, but this varies greatly. When the stomach is in the fasting state, the liver covers over the pylorus. Also in the epigastrium are the left lobe of the liver, pancreas, lesser omentum, and abdominal aorta. In the left hypochondrium are the fundus of the stomach, the tail of the pancreas, the spleen, the left kidney, the splenic flexure, and the left suprarenal gland. In the umbilical region are situated the transverse colon, the junction of duodenum with jejunum, coils of jejunum and ileum, mesentery, abdominal aorta and its bifurcation and the omentum. A throbbing aorta is never seen below the umbilicus. In the hypogastrium are coils of small intestine; the bladder in children; the uterus when pregnant; and a distended bladder in adults. In the right hypochondrium is the liver. The gall bladder is variously placed. Normally it extends but little beyond the liver border and is chiefly in the right hypochondrium. Usually it is a little outside the right rectus muscle at the junction of the epigastrium and right hypochondrium. When distended, it occupies the right lateral abdomen and when greatly distended may be in any region except the left hypochondrium. The hepatic flexure of the colon, the upper part of the right kidney and the head of the pancreas are in the right hypochondrium. The right lumbar region contains the ascending colon; right kidney (small portion) and small intestine. In the right iliac region are the caput coli (cecum), the appendix and the ureter. In the left iliac region is the sigmoid flexure. In the left lumbar, the descending colon and some convolutions of the small intestine; rarely the kidney.

Examination of the Abdomen

1. *Inspection:* Note the general contour: (a) The natural looking abdomen. It is uniform; both sides equal. The surface is a little below the level of the thorax. (b) Lines of the costal grooves; equal or not. (c) Iliac grooves, whether equal or not. (d) Flank lines with the examiner standing in front of the patient. See if the lines of the flanks are exactly equal. Have the patient perfectly straight. Note if normal movements are present. These are: (a) respiratory movements—present or absent; if present note if they are diminished; (b) movements of the abdominal aorta. These are best seen in the umbilical not in the epigastric region. Three movements in the epigastrium: (1) in the costoxiphoid angle is the impulse due to the right ventricle; (2) the impulse of the right ventricle due to displacement of the left lobe of the liver; (3) abdominal aorta itself. Note where the impulse is greatest. In the case of an aneurism, now in the hospital, it is in the epigastrium. Normally we see no abdominal viscera. Sometimes a great deal is seen in: (a) emaciation; (b) after distention from child-birth; (c) after removal of ascitic fluid especially when the recti muscles are separated. Often one sees the stomach; at times the contracting pylorus; also the gall bladder. The liver is often plainly seen. In a case we had in the ward even the notch between the lobes could be seen. It was the first time Osler ever saw the notch. Peristalsis of the small and large intestines is often visible. You may recognize the part of the small intestine as the jejunum when sacculi stand out plainly. A distended bladder is often seen. The edge of the spleen is often visible in patients with ague.

Litten's diaphragm sign. (Charité in Berlin). It is a movable horizonal depression on the lower part of the sides of the thorax during respiration. In the majority of cases it can be seen. It is due to the separation of the costal from the diaphragmatic pleura and is seen in the right hypochondrium; rarely on the left side.

Palpation. Note the general consistency of the abdomen.

It is rigid or spastic? It is usually soft with little resistence. Palpate serrations of the recti; you may mistake them for tumor masses. In health not much of the stomach or intestines can be palpated. In thin persons one can feel the pylorus as a little tubular ridge (the size of the little finger) descending on inspiration. The descending colon and the sigmoid flexure can always be felt as they pass over the brim of the pelvis. The hepatic and splenic flexures of the colon can be felt and recently it has been shown that one can palpate the appendix. Palpate deep down at McBurney's point until the psoas muscle is felt. One feels something the size of a pencil rolling under the finger. You can often get it. The edge of the liver is not usually felt when normal, as it is too thin. Palpate just outside the rectus. It is well to use the thumb alone. The right kidney can be palpated in a normal thin-walled lax abdomen although there is some dispute in regard to this.

SUMMARY OF TYPHOID FEVER CASES

Case I. P. 4

Multiple erythema over joints. Chills without apparent cause.

Case II. P. 5

Thrombus in internal saphenous vein. Phlegmasia rubrum dolens. Chills due to this complication. Relapse without apyrexia. Very high temperature, 107°.

Case III. P. 8

Robert Kuhn. Ambulatory case. Seen in the Dispensary.

Case IV. P. 18

Temperature normal 16th day. Relapse began on 18th day of disease. Not seriously ill. No delirium. On 30th day hemorrhage 600 cc. at 4 p. m.; another at 7 p. m. Temperature dropped between 4 and 6 p. m. from nearly 102° to 96°. Collapse. Died the next day. Blood lost 1200 cc.

Case V. P. 18

Young man, aged 28. Hemorrhage. Two copious hemorrhages one at 7, the other at 8. Temperature not reduced. No recurrence.

Case VI. P. 19

Man of 22 years. Complicated by diphtheria. Raised patch on inner side of lip. Cultures showed Klebs Loeffler bacillus. Diphtheria developed on 17th day of typhoid fever.

Case VII. Pp. 20, 24, 29

Oct. 14. Bed sores. Deep excoriation over sacrum 2 to 3 cm. deep, and on each heel. Only case of bed sores among 32 typhoid fever patients in hospital. Nov. 25. Last seen. Heels nearly well.

Case VIII. Pp. 23, 30, 41, 46, 47

George Carpenter. Admitted Oct. 11. (1) Oct. 12 had hemorrhage, moderate in amount. (2) At 11 p. m. that night slight hemorrhage; temperature not lowered. Oct. 16, 2 a. m. (3) hemorrhage; temperature fell in one hour from 102° to 97.5° at 8 a. m. (4) hemorrhage again 500 cc. Oct. 17. (5) 12 M. 250 cc. Oct. 19. (6) 11 p. m. 200 cc. temperature not influenced. Since then only meteorism. (7) Oct. 25, 2 p. m. severe 500 cc. Blanched him very much. Between Oct. 25-31 bronchitis and bronchopneumonia of the left lung. His blood had 13% mononuclears. Nov. 9, temperature went up. Pneumonia and pleurisy of right side. One liter of turbid fluid removed from chest on 32nd day; died Nov. 12 of intense pleurisy. Autopsy: Intestinal ulcers healing nicely. Summary: 7 severe hemorrhages; 2 nearly fatal.

Case IX. P. 24

Charles Hill. Admitted Aug. 15 (14th day). Temperature 104°. Operated on by Dr. Finney for appendicitis. General peritonitis due to perforation. Recovered from operation. Relapse 35-67th day. Long relapse. Relapse with apyrexia. Nov. 4 venous thrombosis in right leg.

Case X. P. 25

Thomas Nahar, age 37. Seriously ill but temperature low. 101°-102°. Relapse with apyrexia. Short relapse 52 to 67th day.

Case XI. Pp. 39, 46

Martin Broughton. Tender toes with elevation of temperature. Post-typhoid elevation of temperature possibly associated with thrombus in one of the veins of the calf.

Case XII. P. 39

Woman. Relapse. Spleen not palpable as abdomen was rather tense.

Case XIII. P. 39

Relapse following interval of apyrexia. Relapse temperature of 105°.

Case XIV. P. 45

Relapse. Higher temperature 105° than in original attack. Rose spots only in relapse. Tender toes also tender hands and fingers.

Case XV. P. 45

Twenty-one days of apyrexia, then relapse of 15 days duration.

Case XVI. Pp. 48, 61, 72

Anne Andor. Admitted Oct. 17. 1st week of disease. Chlorosis. 49% hemoglobin when admitted. Deafness in this case. On Nov. 9, third week, heart failure. Temperature fell from 105° at 4 a. m. to 98° at 10 a. m. Rose again that evening. Temperature fell to normal 41st day. Very serious case with cardiac failure and anemia. Three days of normal temperature, then relapse.

Case XVII. Pp. 57, 60.

Hebble. Original attack 22 days; relapse 26 days. Relapse without apyrexia. Perineal abscess as a complication.

Case XVIII. Pp. 61, 71, 177

Mrs. Dehl, age 54. Oldest case we have had. Cholecystitis probably due to gallstones and not typhoid fever was final diagnosis.

Case XIX. Pp. 62, 72

Patrick Donahue. Pneumotyphoid. Only case of typhoid fever with leucocytosis. Spleen not palpable.

Case XX. Pp. 62, 71

Luckar. Rose spots everywhere—abdomen, back, legs to ankle, face. Erythema (profuse) over nose and cheek mistaken for erysipelas. Tender toes.

Case XXI. Pp. 72, 85

Joseph Hering. Admitted on 13th day. Purged before admission. One bloody movement following injection of 1 liter of hot water for suppression of urine. In hospital 19 days—died there on 32nd day of the disease. Autopsy: Cloudy swelling of kidney, liver and heart. Healing ulcers: pulmonary edema. This is a case of sudden death in typhoid fever.

Case XXII. P. ——

Shown in Dr. Thayer's Clinic. Not included in the text.

Case XXIII. P. 85

Henry Lee, 28 years. Dec. 31 blood-stained liquid stool; no effect on temperature. Later two bloody stools; the second 200 cc. pure blood. Temperature dropped. Death directly from hemorrhage.

Case XXIV. P. 86

Norris. Colored. House epidemic. Six or seven cases. Well marked diarrhea. Perforation in coil of small intestine in pelvis, from ulcerated Peyer's patch. Large perforation. No fall of temperature. It kept up to 105° until death.

Case XXV. Pp. 101, 139. Zeika. Pneumonia of right lung at onset. Spleen not palpable. Phlebitis of left leg following typhoid fever, probably started in popliteal vein. Congenital lateral nystagmus.

Case XXVI. P. 136

Henry Fink, age 10. Complete paralysis of both extremities following typhoid fever. Typhoid fever 2 years ago. Arms show complete absence of former paralysis.

Case XXVII. Pp. 65, 146

Bessie Massay—colored. Periostitis after typhoid fever. Returned in 1 month with pain in left arm over shaft of humerus. Here first on Dec. 3d. Again Mar. 15th with pain in both arms.

Case XXVIII. P. 141

John Lehmnell, age 25 years. Mild attack of typhoid fever in Sept. in Johns Hopkins Hospital. Returned Mar. 5, with cholecystitis. Attack lasted 6 days, or rather had fever during that time.

APPENDIX

THE JOHNS HOPKINS MEDICAL SCHOOL

Class of 1898 **

*Baer, William Stevenson—A. B. 1894; R. H. O. and Asst. Res. Surg. 1898-00; Asst. Inst. and Assoc. in Orthoped. Surg. 1900-10.—Visit. Orthoped. Surg. J. H. H., Cambridge Hosp., Union Prot. Infirmary, Church Home, Robt. Garrett Hosp. for Children and Home for Incurables; Surg. in Chg. Ortho. Disp. and Assoc. Consult. Orth. Surg. Sheppard & Enoch Pratt Hosp.; Assoc. Prof. Clin. Ortho. Surg.; Member Alumni Council. Lt. Col. M. C. (Died 1931.)

*Calvert, William Jephtha—A. B. Kentucky 1893; 1st Lieut. and Asst. Surg. U. S. A. Fort McHenry 1898-02; Lect. Trop. Diseases, Washington Univ. St. Louis 1902-03; Prof. Phys. Diag. and Clin. Pathol. Univ. of Missouri 1903-09; Baylor Univ. Dallas, Texas 1910-11; Prof. Prevent. Med. Univ. of Mo. Columbia 1911-14; Prof. Clin. Med. Baylor Univer. 1914-19.—Physician. (Died Mar. 21, 1945.)

*Cassidy, Patrick Joseph—A. B. Yale 1894; Asst. Res. Phys. Backus Hosp. 1898-99; Visit. Surg. Harris Mem. Hosp. 1898-06.—Visit. Pathol. and Surg. Backus Mem. Hosp.; Councilor Conn. State Med. Assn. and Physician, Norwich, Conn. (Died Jan. 28, 1918.)

*Coe, John Williams—Ph. B. Yale 1893; Senior Asst. House Staff Presbyterian Hosp., N. Y. 1898-1899, and Res. Phys. 1899-00.—Asst. Clin. Pathol. Cornell Univ. and Physician, N. Y. (Died March 6, 1911.)

Dawson, Percy Millard—A. B. 1894; Fellow, Asst. Instr. Assoc. and Assoc. Prof. of Phys. 1898-09; Spec. Student, Harvard Div. Sch. Cambridge, Mass. 1909-10; Minister 1st Unitarian Church, Ann Arbor, Mich. 1910-12.—Asst. Prof. of Physiol. Univ. of Wis. Madison, 1916-25; Assoc. Prof. 1925-32; advisor in Exp. College of U. of Wis., 1927-29; Visiting Professor of Physiol. Duke University, 1943-46. 665 East Maryland Ave., Claremont, Calif.

*Elting, Arthur Wells—A. B. Yale 1894; R. H. O. 1898-99; Asst. in Pathol. Albany Med. Sch. 1899-00.—Surg. Child's Hosp., Albany Hosp., Prof. of Surg. Albany Med. Sch. 1911—Surgeon, Albany, N. Y. Lt. Col., M. C. (Died Jan. 2, 1948.)

*Ford, William Webber—A. B. Western Reserve, 1893; D. P. H. McGill 1900; R. H. O. 1898-99; Fellow, Pathol., McGill Univ. 1899-01: Fellow, Rockefeller Inst. for Med. Research; Inst. for Infect. Dis.

** Data kindly furnished by Dr. Alan M. Chesney, Dean of The Johns Hopkins Medical School.

*Deceased members.

Berlin 1901-02, and J. H. U. 1902-03; Instr. and Assoc. in Bacteriol. 1903-06; Assoc. Prof. of Hyg and Bacteriol. and Lect. in Legal Medicine 1906-1917; Lecturer in Hygiene and Prof. Bact. Sch. Hygiene and Pub. Health. (Died 1941.)

*Hastings Thomas Wood—A. B. 1894; R. H. O. 1898-99; Surg. Hospital Ship "Maine" 1899-00; Prof. Clin. Pathol. Cornell Univ. Med. Coll. 1903-19; Major, M. C. 1917-18; Asst. Attend. Phys. Bellevue Hosp. Visit. Phys. St. Barthol. Hosp. and Clinic; Consult Nassau Co. Hosp. Mineola, L. I.—Physician. (Died Dec. 5, 1942.)

*Herrick, Alfred Birth—A. B. Williams 1894; R. H. O. 1898-99; Res. Phys. National Soldiers Home 1899-00; Res. Surg. Barnes Hosp. Washington, D. C. 1900-04; Chief Surg. Clinic, Ancon Hosp. C. Z. 1904-15.—Surg. Hosp. de Panama. (Died 1937.)

Knox, James Hall Mason, Jr.—A. B. Yale 1892, and Ph. D. 1894, A. M. Lafayette 1896; R. H. O., Asst and Instr in Ped. 1898-09. Lecturer in Child Hygiene, Johns Hopkins School of Hygiene and Public Health—Asst. Visit. Pediatrician, Dispen. Phys. and Assoc. in Clin. Ped.; Phys. in Charge, The Thomas Wilson Sanitarium; Pres. Babies Milk Fund Assn. Chief of the Bureau of Child Hygiene, State Depart. of Health, Maryland, 1922-23; Consultant to the Bureau, 1942–, and Physician, 2411 No. Charles St., Baltimore. Maj. A. R. C.

*Langfeld, Millard—A. B. 1893; Bacteriol. Omaha City Brd. Health; Member Omaha Milk Com.—Supt. and Dir. in Chg. Labs. Cudahy Pack. Co., Omaha, Neb. (Died 1937.)

Light, Gertrude Underhill—S. B. Wisconsin 1894; Phys. Randall's Island Hosp. for Children N. Y. 1898-99; Dmnstr. Pathol. Wisconsin Coll. of P. and S. 1899-00; Clinical Asst. Bellevue Hosp. Disp. 1900-02; Sanitary Inspec. Tenement House Dept. New York 1902-1918.—Sheppard-Towner bill State of N. M. Santa Fe.

Madison, James Daniel—S. B. Wisconsin 1894; R. H. O. 1898-99; Asst. Res. Phys. Danvers Insane Hosp. Mass. 1899-02.—Visit. Phys. Milwaukee Hosp. Johnson Emerg. County and Columbia Hospitals and Physician, 425 East Wisconsin Ave., Milwaukee. Capt. M. C.

*Marshall, Harry Taylor—A. B. 1894; R. H. O. 1898-99; Fellow 1899-00; Asst. Res. Pathol. and Instr. in Pediatrics 1900-06; Pathol. Bureau of Science and Prof. Pathol. and Bacteriol. Sec. and Registrar, The Philippine Med. Sch. Manila 1906-08—Mbr. Va. St. Bd. Hlth.; Prof. Pathol. and Bacteriol. Univer. of Va. Charlottesville. (Died 1929.)

*Perkins, Roger Criswold—A. B. Union 1893, and Harvard 1894; Res. Pathol. Lakeside Hosp. Cleveland 1898-01; Lect. in Bacteriol. West. Reserve Med. Sch. Cleveland 1901-04; Asst. and Assoc. Prof. of Pathol. and Bacteriol. 1904-10—Prof. of Hygiene and Preventive

* Deceased members.

Med. and Consult. in Hygiene, U. S. P. H. S.; Chief Lab. Div. Health, Dept. Pub. Welfare, Cleveland; Maj., A. R. C. (Died 1936.)

*Porter, Katherine—A. B. Bryn Mawr 1894; House Phys. and Asst. Surg. N. Y. Infirmary for Women and Children 1898-04; Externe Orange Mem. Hosp. Disp. 1900-07; Phys. Children's Aid and Protective Society of the Oranges 1899-15; Med. Insp. Orange Public Schools, 1909-15; c/o Internat. Bank. Corp'n. Peking China, 1915-19; Med. Adviser of Women, Cornell Univ., Ithaca, N. Y. 1919-20; Physician, East Orange, N. J. (Died 1944.)

Pratt, Joseph Hersey—Ph. B. Yale 1894; A. M. Harvard 1901; Asst. Pathol. City Hosp. Boston 1898-00; Instr. Pathol. Harvard; Asst. Visit. Visit. Pathol. City Hosp. and Asst. Pathol. Children's Hosp. Boston 1900-02; Instr. in Med. Harvard 1902-18; Asst. Visit. Phys. Mass. Gen. Hosp. 1910-18. Prof. Clinical Med., Tufts Medical School, 1929-47. Phys.-in-Chief, Boston Dispensary, since 1927, and Joseph H. Pratt Diagnostic Hospital, 1938–; Physician, Boston, Mass. Major, M. C. 1917-1918.

Sands, Georgiana—(Mrs. Leo Loeb)—A. B. Vassar 1893; Grad. Student, Barnard 1893-94; R. H. O. 1898-99, 6803 Kingsbury Blvd., St. Louis, Mo.

*Schenck, Benjamin Robinson—A. B. Williams 1894; R. H. O., Asst. Res. and Res. Gynecol. and Instr. 1898-03.—Assoc. Prof. Gynecol. Detroit Coll. Med. and Surg.; Gynecol. Harper Hosp.; Consult. Obstet. Woman's Hosp. and Physician, Detroit. (Died June 30, 1920.)

*Steiner, Walter Ralph—A. B. Yale 1892, and A. M. 1895; Grad. Student 1892-94; R. H. O. 1898-99; Asst. Visit. Phys. Hartford Hosp. Conn. 1905-07, Pathol. and Bacteriol. 1901-12; Sec. Conn. State Med. Soc. 1905-12.—Consult. Pathol. and Bacteriol. and Visit. Phys. Hartford Hosp.; Consult. Phys. Middlesex Hosp. New Britain Hosp. and Hartford Orphan Asylum; Sec'y Cong. Amer. Physicians and Surgeons; Physician, Hartford. (Died Nov. 4, 1942.)

Walker, Emma Elizabeth—A. B. Smith 1887,—Mem. N. Y. Co. and State Med. Soc. N. Y. Acad. of Med. and Physician, 600 West 113th St., New York; Lect. War Dept. 1918-19.

*Whitridge, Andrew Henderson—S. B. Harvard 1894; R. H. O. 1898-99. (Died March 19, 1912.)

* Deceased members.

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